Synergy Medical

NEW PATIENT INFORMATION

Date:_____**Name:** _____**Birthdate** _____ **Sex** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Please circle: Married Single Widowed Divorced Domestic Partner Legally Separated Life Partner
Sexual orientation: homosexual, heterosexual, Bisexual, Choose not to disclose
Gender identity: Identifies as Male/ Female, Transgender,Choose not to disclose
Assigned sex at birth: Male, Female, Choose not to disclose
Pronouns: he/him, she/her, they/them

PATIENT'S ETHNICITY

_____Hispanic or Latino _____Not Hispanic or Latino _____Unreported/Refused to Report

RACE:

_____Asian _____Black/African American _____American Indian/Alaska Native _____White

_____ Unreported/Refused to Report

PREFERRED LANGUAGE:

_____English _____Indian (including Hindi & Gujarati) _____Spanish _____Other

CONTACT INFORMATION:

Primary Phone: _____Home Cell Work Other:_____
Secondary Phone: _____Home Cell Work Other:_____

Email Address_____

Occupation: _____ **SSN#:** _____

Name and telephone number of someone to reach in case of an emergency,

_____
NAME PHONE RELATIONSHIP

Name:_____ **D.O.B.**_____

Type of Health Insurance:_____

Please provide primary health insurance cardholder's name and date of birth

Does your Insurance policy require a designated lab? If so, please specify: _____

Synergy Medical

Patient Name_____**Birthdate:**_____**Physician:**_____

Thank you for choosing Synergy Medical PC as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Patient Financial Responsibility Policy, which we require you to read and sign prior to seeing the physician. Please let us know if you have any questions or concerns.

I understand all copayments, co-insurance and past due balances are due and payable at the time of service. For your convenience, we accept cash, check, Visa, MasterCard, American Express, and Discover.

I understand I am financially responsible for treatment provided to me or my legal dependent by Synergy Medical PC. This includes physicals, office visits, procedures, lab or diagnostic testing ordered by my physician.

I understand my insurance policy is a contract solely between me and my insurance company. It is my responsibility to know if my insurance company has any deductibles, copayments, co-insurance, out-of-network or benefit limitations for medical, lab or diagnostic services. I understand that, as a courtesy, my physician will submit a claim to my insurance plan. I authorize my insurance plan to make payments for covered services directly to my physician.

I authorize Synergy Medical PC to communicate with my health insurance company, in accordance with their Privacy Policy, regarding my policy coverage. I further authorize Synergy Medical PC to release information required by my insurance company to make payment for services rendered.

If there is a balance on my account, a statement of my charges and payment will be sent to my mailing address. A payment plan may be set up if I have financial difficulties.

I understand appointment cancellations with less than 24 hour notice or "No Show" patients can be charged a service fee of up to $20.00 for missed office visit. I understand I am responsible for this fee. I understand it cannot be billed to my insurance plan.

I have read the Patient Financial Policy and understand my responsibilities.

_____ _____

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

Synergy Medical

PATIENT CONSENT

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at Synergy Medical P.C., and I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary to me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I understand that if I do not follow my Physician's recommendations as they may relate to my health, that the Physician and this office will not be responsible for and injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with the Physician's office is exposed to my blood or body fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV.) I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

I understand my right to request the presence of a chaperone during my visit. The chaperone may be a patient advocate or staff member. Our staff will maintain patient confidentiality standards set by Synergy Medical P.C. When a chaperone is present, the provider will try to keep all questions of a sensitive nature to a minimum.

2. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that the Physician's office may collaborate with other heath care providers to coordinate, manage and provide health care to me and I consent to the Physician's office sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.) I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (HER) will be accessible by Health credentialed physicians/practitioners as well as other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA.) The Physician's office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with the Health HER system, I agree that the Physician's office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, manages care-organizations, my employer (if I am injured at work), state and federal government programs, Worker's Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to the Physician's office request of my health information from other providers of care of me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as the Physician's office participation in any health information exchange described in the Physician office's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

3. ACKNWOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Physician office's Notice of Privacy Practices which provides information on how the Physician's office may use or disclose PHI for purposes of treatment, payment, or health care operations. **Please Initial** _____

4. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician's office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

5. FINANCIAL RESPONSIBILITY

I understand and agree that I am responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan.) Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

6. PERSONAL VALUES

I understand that the Physician's office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician's office.

Patient Name: _____ **Patient Date of Birth:** _____

_____

Patient Address / City/State /Zip / Code

_____ _____ _____

Signature of Patient or Patients' Legal Representative **Date of Signature** **Time of Signature**

_____ _____

Print Name of Patient's Legal Representative **Relationship of Legal Representative to Patient (e.g., parent, guardian, other, please explain)**

7. MEDICAL INFORMATION RELEASE

I authorize the release of information including diagnosis, records, examinations rendered to me, and claims information.

This information may be released to:

□ Spouse Name: _____

□ Children Name(s): _____

□ Other Name(s): _____

□ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ **Date:** ___ / ___ / ___

Synergy Medical

MEDICAL HISTORY FORM

Name: (last) _____ (first) _____ Date of Birth: _____SEX: M/F
Mail Order Pharmacy:_____ Phone:_____
Local Pharmacy:_____ Phone:_____
Language Spoken at home:_____

MEDICATIONS:
Please list all medications (include over-the-counter?)

In preparation for your visit bring all medications, inhalers, Vitamins, or supplements in their original bottles.

NAME STRENGTH FREQUENCY

1._____
2._____
3._____
4._____

ALLERGIES:
Are you allergic to any drugs or medications?

☐ NO ☐ YES If yes, what

Do you have any food allergies?

☐ NO ☐ YES If yes, what?

5. _____
6. _____
7. _____
8. _____

FAMILY HISTORY: (Cancer/BP/Diabetes/Bleeding Disorder/Anemia, etc.)

MOTHER: _____ BROTHER: _____

FATHER: _____ SISTER: _____

OTHER: _____

ADVANCED DIRETIVES – Y/N

LAST MAMMOGRAM – *FACILITY-*

LAST COLONOSCOPY- *FACILITY-*

PAST MEDICAL HISTORY/SURGERY

1._____ 2._____

3._____ 4._____

Communicate with us securely ONLINE

The **"Patient Portal"** is a service we provide to our patients that integrates with our electronic medical record and provides more efficient service to you.

THE PATIENT PORTAL SHOULD ONLY BE UTILIZED FOR ROUTINE MATTERS AND SHOULD **NOT** BE UTILIZED FOR URGENT ISSUES.

Services that are available in the **"Patient Portal"**:

- Request medication refills
- Receive test results
- Request referrals to specialists
- Instant access to your medical records
- Ask your physician a question

Access the Patient Portal at www.drgandhimd.com

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Complete the information listed below. Once this form is received, you will be given a temporary password that you need to create your portal account.

Patient's First Name: _____ Patient's Last Name: _____

Patient's Birth Date: _____

Patient's CURRENT Email address: _____

Synergy Medical

Thank you for partnering with our office and taking an active role in your health. In order to enhance our partnership it is important we share some helpful practice information

Our office hours are: *Monday – Thursday 8:45 a.m. – 5 p.m.*
Friday 8:45 a.m. – 4:30 p.m., and 1-2 Saturdays per month from 9 a.m.-1 p.m.

After hours you will be directed to our answering service for further instructions

(Please call during business hours for prescription refills)

We have developed a partnership with *Healthy Urgent Care or St. Joseph Mercy Canton Urgent Care* and they will forward their findings to our office the following day. Should you find yourself in a situation where you must seek medical care after hours and it is **not** a life threatening emergency please use:

Healthy Urgent Care
29531 Plymouth Road
Livonia, Michigan 48150
P) 734-525-7939
Hours ***Mon-Fri 8 a.m.-8 p.m.***
Sat-Sun 8 a.m.-6 p.m.

St. Joseph Mercy Canton
1600 S Canton Center Rd
Canton, MI 48188
P) 734-398-7557
Hours ***Mon-Sun 8 a.m.-10 p.m.***

(Please also contact our office for follow up)

Should you have a life threatening emergency please proceed to the nearest hospital

Ask about our Patient Web Portal. We have a Patient Portal that supports two-way, secure and compliant communication.

Ask any of our staff about Community Services or contact the following:

NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health and social needs (i.e., utilities, housing, health insurance, food, diapers, etc.)

A listing of the area resources can also be found on this website:
http://www.referweb.net/uwjc

PCP Patient Provider Agreement

SYNERGY MEDICAL

9216 Middlebelt Road, Livonia, MI 48150

A Patient Centered Medical Home is a partnership between a patient and their physician.

We trust you as our patient to:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your doctor about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor *first* with all problems, unless it is a medical emergency
- Consult my doctor before going to a specialist

A Patient-Centered Medical Home (PCMH) is a system of care in which a team of health professionals work together to provide your entire healthcare needs. You, the patient, are the most important part of a patient centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

As your Patient Centered Medical Home physician I agree to:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to your feelings and questions to help you make decisions about your care
- Keep your treatments, discussions, and records private
- Provide 24 hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- Give you clear directions about medicines and other treatments
- Refer you to specialists as needed
- End every visit with clear instructions about expectations, treatment goals, and future plans