Oakland Medical Center

115 E Long Lake Road, Troy, MI 48085-5524
Phone (248) 828-7500 Fax (248) 813-6518
www.oaklandmedicalcenter.com

Thank you for choosing Oakland Medical Center as your Patient-Centered Medical Home

We ask that you complete the enclosed paperwork and bring it with you at the time of your appointment. We also ask that you arrive 15 minutes prior to your appointment to complete any additional paperwork. Please be ready to provide your insurance card and photo ID.

Appointments:

We have reserved a specific time for you to see the doctor. We understand that there are circumstances that require you to either cancel or reschedule your appointment. We would appreciate a 24-hour notice whenever possible. Failure to cancel your appointment without a 24-hour notice will result in a $25 no show fee.

Medication Refills

To obtain a refill of your medication, be sure to know the medication name, strength and dosage, as well as a pharmacy name and phone number when calling for a refill. Please allow 24 hours for refills. Refill requests called in after 3:00 pm on Friday will not be processed until the following Monday. If you have not seen the doctor within a 3-6 month period, you may be required to see the doctor prior to obtaining a refill.

Insurance/Payments

There are many variations of insurance plans, we are unable to know your individual coverage. We help whenever we can, however it is your responsibility to know your plan coverage. Copays, balances and charges for non covered services are expected at the time of service.

Additional Fees

Forms and letters- $10 for single page forms, $15 for multiple page forms and $25 for more complex forms- payable at the time paperwork is given to us. One weeks' notice is absolutely required. Chart copying-starts at $25 with a record release completed by the patient. We would appreciate a ten day notice whenever possible.

Perfume & Cologne

For the benefit of our patients and employees with allergies or breathing difficulties, we ask that you do not wear perfume or cologne to your appointment.

Thank you,
Oakland Medical Center Staff

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Patient Information Form

Patient Name: _____ Date of Birth: _____ Age: _____

Race: (Please Circle) White Hispanic African American Native-American Asian Other

Ethnicity: (Please Circle) Hispanic/Latino Other Preferred Language: _____

Sex: _____ Marital Status: (Please Circle) Single Married Divorced Widowed

Social Security #: _____ Email: _____

Address: _____ City, St, Zip: _____

Home #: _____ Work #: _____ Cell #: _____

If Minor, Parent/Guardian Name: _____ Relationship: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

Insurance Information

Primary Insurance Carrier Name: _____

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Subscriber's Employer: _____ Work #: _____ Relationship: _____

Secondary Insurance Carrier Name: _____

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Subscriber's Employer: _____ Work #: _____ Relationship: _____

Privacy

Do we have your permission to leave a message on your answering machine / voice mail regarding appointment, Billing or test results? (Please Circle) Yes No Other # Please Specify: _____

Patient Initials: _____

May we call you at work? (Please Circle) Yes No

Due to the extent of the new governmental privacy laws, we ask that you list how you would like to be addressed in order for us to insure your privacy. Please address as (example Mr. Smith or Joe) _____

Financial Arrangements

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services are due at the time services are rendered unless we participating with your insurance and we are aware you have coverage for the visit. Please check with your insurance company to verify that the doctor you are seeing is a participating physician. ***You will be responsible for any copays, deductibles, and non-covered services. Payment of copays and non-covered services are expected at the time of services. In the event you do not have insurance coverage, we expect payment in full at the time of services.***

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filling of insurance claims are a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Should problems arise affecting your timely payment of this account, we encourage you to contact us promptly for assistance.

Certification

I have read and understand the above financial arrangement. I authorize my physician to submit my medical claims to my insurance for payment of services rendered.

Patient Signature: _____ Date: _____

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Medication Information

Patient Name: _____ Date of Birth: _____

Home #:_____ Work #: _____ Cell #:_____

Pharmacy Name:_____ Phone #: _____

Mail Order Pharmacy: _____ Mail Order ID #:_____

List of Allergies: _____

_____

Medications

To assist the physicians and practitioners with your future medical evaluations, please list all current medications that you are taking, including over the counter medications. Including the name of the medication, the dosage, how many pills you take and how many times per day you take it, and whether your medications are called in to a local pharmacy for refills or obtained by mail order.

Medication Name	Dosage (mg)	How Often Taken	Type Of Order
			☐ Local Pharmacy ☐ Mail Order
			☐ Local Pharmacy ☐ Mail Order
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A Patient-Centered Medical Home is a Partnership Between the Patient and their Physician

Being a part of Patient-Centered Medical Home, your doctor will:

- Work with you to improve your health
- Review your medications at every visit and discuss with you any interactions or contraindications
- Electronically prescribe your medications to ensure they are accurate and available to you promptly
- Develop a personal action plan with you to address your chronic conditions
- Set goals with you and monitor your progress
- Use computer technology to monitor your progress and determine if your health is improving
- Inform you of all test results
- Help you take control of your health by providing you educational material, hosting group visits and linking you to other community programs and resources
- Provide you 24 hours access to a clinical decision-maker by phone
- Have arrangements with after-hours care to be informed of your visit or emergency treatment within 24 hours or next business day
- Reserve space in our schedule for you to accommodate a same-day appointment

By choosing to participate in a Patient-Centered Medical Home, I agree to:

- Make sure my doctor knows my entire medical history
- Tell my doctor all of the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Adhere to the action plan designed by my doctors
- Consult my doctor before making my own appointment with a Specialist
- Request that any other doctor I see send my doctor a report, copies of lab work, test results, and x-rays
- Know my insurance and what it covers
- Provide the office feedback on how they can improve

Certification

I have read and understand the above information. I will participate in the Patient-Centered Medical Home.

(Please Circle) Yes No

Patient Signature: _____ Date: _____

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Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations and Acknowledgement of Receipt of Notice of Information Practices

I understand that as part of my healthcare, Oakland Medical Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I can request a *Notice of Information Practices and Patient Responsibility* form at any time, for a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Oakland Medical Center reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request amendments be made to my medical record. I understand that the six-year history of all disclosures will be accessible to me including the purpose of the disclosure(s) and the address of the recipient. I may receive a copy of this history within 60 days of my request and I understand that I may have to pay a reasonable charge of $.05 per page for any copies.

Patient Name: _____

Patient Signature: _____ Date: _____

I request that all communications to me regarding appointments, billing, or test results, by telephone by Oakland Medical Center Staff be handled in the following manner:

For oral communication, call:_____

May we leave a message on an answering machine? (Please Circle) Yes No

May we leave a message with a family member? (Please Circle) Yes No

If yes please specify which family member(s): _____

What information can be left with these family members? Please check the boxes that apply

☐ Billing Information ☐ Appointment Information ☐ Test Results ☐ General Health Information

Address to send written communications _____

May we call you at work? (Please Circle) Yes NoPhone number: _____

Can we leave a message at this number? (Please Circle) Yes No

Patient Signature: _____ Date: _____

Witness Signature: _____