Timothy Lamb M.D. New Patient Questionnaire

INTERNAL MEDICINE PRIMARY CARE PHYSICANS

MICHIGAN HEALTHCARE PROFESSIONALS

AFFILIATED WITH SJMO & BEAUMONT

Name: _____ D.O.B.:_____

Email: _____ S.S.N: _____

Gender at Birth: Male or Female Gender Identity: Male or Female Sexual Orientation:_____

Name of Physician you are seeing today: _____

Emergency contact Name: _____

Relationship: _____ Contact Number: _____

Reason for visit: _____

Chronic Illnesses:

Do you have any chronic illnesses? No: _____ Yes: _____ if yes, please check all that apply:

Diabetes: ____ Hypertension: ____ Hypercholesterolemia: ____ Asthma: ____

Heart Disease: ____ Stroke: ____ Headaches: ____ GERD/Ulcers: _____

Arthritis: ____ Depression: _____ Anxiety: ____ Pain: _____

Other: _____

Medications:

Are you currently on any medications? No: ___ Yes: ___

If yes, please list medications and dosage if known:

_____ _____

_____ _____

_____ _____

Pharmacy Name: _____Phone Number: _____

Mail order pharmacy: _____

Allergies:

Are you allergic to any medication? No: ___ If yes, name? _____

Are you allergic to any foods? No: ____ If yes, name? _____

Any other allergies the doctor should know about?

_____

_____

Current/Previous Physicians / Specialists:

_____

_____

Eye Doctor: _____ Foot Doctor: _____

Dermatologist: _____ Endocrinologist: _____

Timothy Lamb M.D.

New Patient Questionnaire

Surgical History:

_____

_____

Family History:

Diabetes: ___ High Blood Pressure: ___Asthma: ___ Heart Disease: ____ Stroke: ____

Blood Disease: ___ Cancer: ___ Epilepsy: ___ Kidney Disease: ____

GERD/ Ulcers: ___Rheumatoid Arthritis: ____ Thyroid Disease: ___

Other: _____

Social History:

Occupation/ Employer: _____ Are you Retired: _____

Do you smoke? No: ___ Yes: ____ If yes, please list quantity: _____

Have you ever smoked? No: ___ Yes: ___

Do you drink alcohol? No: ___ Yes: ___ If yes, please list quantity: _____

Do you drink any caffeine beverages? Yes: ___ No: ___ If yes, please list quantity: _____

Sources: Coffee: _____ Tea: _____ Energy Drinks: _____ Soda: _____ Tablets: _____

What is your activity level? Circle all that apply: Walking, Running, Biking, Gym Training.

How many times a week? 1-2 2-3 3-4 4-5 5-6 6-7

Do you use illicit drugs? No: ___ Yes: ___ If yes, please list type: _____

Health Maintenance:

When was your last physical? _____

When was your last EKG? _____

Adult women only:

Last menstrual cycle? _____

Birth Control: _____

When was you last Mammogram? _____

When was your last PAP smear? _____

How many children? _____

Adults age 35 and older:

When was your last A1C check: _____

When was your last cholesterol check: _____

Adult men over age 50 only:

When was your last prostate exam? _____

Adults over age 50 only:

Date of last colonoscopy: _____

Date of last eye exam: _____

When was you last DEXA scan (osteoporosis screening)? _____

Immunizations: (If you have records please bring a copy)

Date of last flu shot? _____

Date of last pneumonia shot? _____

Date of your last tetanus shot? _____

Dates of your last shingles shot? _____

Date of your Hepatitis A shot? _____

Date of your Hepatitis B shot? _____

Dates of your Meningitis shots? _____

Dates of your last Gardasil shot? _____

Turn over ->

Internal Medicine Primary Care Physicians

Dr. Timothy Lamb

A. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare or your Commercial insurance doesn't pay for services done today with your provider, you may have to pay.

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services provided by your provider.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ OPTION 1. I will pay now for any services rendered that I am responsible for, co-pay's, deductible, but I also want my insurance billed for an official decision on payment, which is sent to me on a benefit summary report. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions given by my insurance. If my insurance does pay, you will refund any payments I have made.

☐ OPTION 2. I want the services provided, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

☐ OPTION 3. I don't want the services provided. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Name: _____

Date of Birth: _____ Date of Visit: _____

Social Determinants of Health
Please circle the answer that best fits you:

1: Within the past 12 months we worried whether our food would run out before we got money to buy more?

Often True **Sometimes True** **Never True**

2: Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?

Yes or No

3: In the past year, has the utility company shut off your service for not paying your bills?

Yes or No

4: In the last 12 months, did you skip medications to save money?

Yes or No

5: In the last six months, have you ever had to go without health care because you didn't have a way to get there?

Yes or No

6: Do problems getting child care or elderly care make it difficult to work or study?

Yes or No

7: Do you need any assistance with finding a local career center or job training?

Yes or No

8: I have trouble understanding my doctor's written instructions.

Yes or No

9: How often do you feel lonely?

Often **Some of the time** **Hardly ever** **never**

10: Do you ever feel unsafe in your home or neighborhood?

Yes or No

11: For those needs identified, which would you like help with? (Please write the number)

12: Can we share this information with organizations to whom we make referrals to address these needs?

- **Yes or No**

PAYMENT OPTIONS

Payments may be made by mail, by phoning (855) 841-2284 or electronically on our website at www.impcp.com. We accept cash, checks made payable to MHP or credit card payments. All returned checks will be charged $30.

FINANCIAL HARSHIP SUPPORT SERVICES

Financial Hardship Support Services are available. Please call the Billing Department at (855) 841-2284 to schedule an interview.

A. MONTHLY BUDGET PLAN

1. Monthly Budget Plans will be approved on a case by case basis and require a patient commitment to comply with the terms of the Budget Agreement.
2. A Budget Agreement must be executed prior to the start of a Monthly Budget Plan.
3. Patients approved for the Monthly Budget Plan will receive "one monthly" statement. Failure to make payment by the due date will automatically terminate the Budget Agreement and may result in Account being transferred to a Collections Agency and discharge from the Practice.
4. A credit card will be requested to process Budget payments. Office visits will be scheduled during timely payments.

B. HARDSHIP APPLICATION

Hardship status may be established for patients to excuse them of some or all of their existing debt to the practice. However, all patients are required to follow the Hardship Application process to be eligible for such relief.

1. Call the Billing Department at 855-841-2284 to schedule an interview.
2. Complete the Hardship Application during the interview with the Billing Department. Please bring documents to the interview that support your case which may include any of the following:
   - W-2 withholding statements
   - Pay check stubs
   - Income Tax return
   - Forms from Medicaid or other State-funded medical assistance
   - Forms from employers or welfare agencies
   - Bankruptcy Settlement
   - Catastrophic situations (death, disability in family or divorce)
   - Other documentation that shows that you would be unable to pay medical bill and still be able to pay for other basic necessary expenses
3. You will be notified of approval decision within ten business days after submitting the Hardship Application.
4. If your Hardship Application is not approved, a monthly Budget Plan will be available.

- **Discharge from the Practice for financial non-compliance** will result only after all above-mentioned options are exhausted. If this becomes necessary, a one-time 30 day prescription will be provided and records faxed to your new doctor upon written request.

PATIENT FINANCIAL AGREEMENT

Thank you for choosing our practice to serve your Healthcare needs. Please be aware that we operate under our parent company, Michigan Healthcare Professional, PC. Therefore, all correspondence and statements will come in the name of Michigan Healthcare Professionals, PC. Your satisfaction and meeting your expectations are important to us. In order to provide quality medical services and support your ongoing health, we believe it is important to inform you of the financial policies we've established to support the delivery of our services. By informing you of these policies, we believe it will enable you to understand our expectations, as we strive to meet yours, and ultimately support a more mutually beneficial relationship. Please read our Patient Financial Agreement and accept by signing below.

- All fees are **patient's responsibility**. Co-pays, deductibles and non-covered services are collected at the time of service. Patients with NO insurance are expected to pay in full at the time of service.
- **We request you present your insurance card and ID at every visit.** This process supports our effort to bill your insurance company promptly and accurately, on your behalf. It is your responsibility to inform our staff of any insurance changes or changes of your address. Failure to report such changes, beforehand, or on the date of a visit may result in the practice being unable to bill the correct insurance company and become your responsibility to make payment.
- MHP will submit claims to your insurance company as a convenience. The contract between you and your Insurance Company is not a guarantee of payment. Please **familiarize yourself with your policy's deductible, co-payment, coverage's, fees, Primary Care Physician election & Network.** If a designated Primary Care Physician is required, you must be sure our doctor is elected. If our doctor is not in your "Network", your out of pocket costs may be higher.
- **"No Show" patients or cancellations with less than 24 hours** prior notice to visit, may be charged $35. Chronic "No Show" patients may be discharged from the practice.
- **Workers Compensation and / or Automobile Claim** disputes do not eliminate patient's financial responsibility. Your Health Insurance will not be billed until the dispute is settled. Therefore, your statements may be delayed as well. Any necessary medical records will be provided at your request. The cost for such records will follow the current rate as amended to the Medical Records Access Act, Public Act 47 of 2004, MCL Section 333.26269.
- Statements are mailed monthly. The following is our Statement Protocol:
  1) Following your service, we will bill your insurance company. Based on their response, you will receive a statement for any fees that were not covered by your insurance. Payment is due upon receipt.
  2) If your payment is not received within 30 days of the first statement, a second statement will be mailed. Payment is due upon receipt.
  3) If your payment is not received within 30 days, you will receive a final notice in the form of a Demand Letter. Payment is due upon receipt.
  4) Failure to make payment in response to the Demand Letter or to establish a "Monthly Budget Plan or Hardship Application" may result in your Account being transferred to a Collections Agency and you being discharged from the Practice.

I understand and accept the terms of this patient Financial Agreement as stated above.

Print Patient Name: _____ Date: _____

Patient/ Guardian Signature: _____

INTERNAL MEDICINE PRIMARY CARE PHYSICIANS

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

When you schedule an appointment with Internal Medicine Primary Care Physicians we set aside enough time to provide you with the highest quality care. Should you need to change an appointment please contact our office as soon as possible and at least 24 hours prior to your scheduled appointment, to avoid fees. Please see our appointment cancellation/ no show policy below:

- Effective August 17, 2022 any established patient who fails to show up or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a no show and charged a $35.00 fee for 15 minute appointments and $50.00 for 30 minute appointments.
- A second no show or missed appointment in a row will result in a $100.00 fee regardless of allotted time.
- If a third no show or cancellation/reschedule with no 24 hour notice should occur, the patient will be discharged from Internal Medicine Primary Care Physicians.
- Any new patient who fails to show for their initial visit will be charged $35.00. After a second no show you will not be rescheduled.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office manager, who may be able to waive the no show fee. You may contact Internal Medicine Primary Care physicians during regular scheduled hours of operation at the number below, should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

248-253-1468 or email at ifrontdesk@cava.cc

_____, I have read and understand the medical appointment cancellation/no show policy and agree to its terms.

_____ Signature _____ Date

Patient/Physician Agreement
Patient-Centered Medical Home

This agreement is used to recognize the dedication between the patient and physician. By signing this agreement, both parties will commit to following it to the best of their ability. This agreement is between Timothy Lamb (physician) and _____ (patient).

Physician Commitment to Physician Responsibilities

Timothy Lamb is dedicated to providing the highest quality patient care. The staff and doctor provide healthcare services without regard to race, ethnicity, nation origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Dr. Timothy Lamb is committed to ensuring your rights as a patient, including your right:

- To information about your rights and responsibilities, our organization, our services and our practitioners and providers
- To participate in all decision making regarding your health care and to extend your decision-making rights to parents, guardians, family members or other conservators if you are unable to fully participate in your treatment decisions (advance directives)
- To discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
- To voice complaints or appeals about the organization or care provided and to receive information on the grievance procedures for this practice and your applicable health plan
- To be treated with respect and courtesy and with recognition of your dignity and right to privacy

Patient Commitment to Patient Responsibilities

To ensure the delivery of the best quality of care, we ask that you:

- Maintain a good relationship with your primary care physician and communicate when you have questions or concerns about your healthcare;
- Provide the information needed by your physician and other healthcare professionals in this medical home in order to provide you with care;
- Follow through with the healthcare plans and instruction agreed to with your physicians and other health care providers;
- Educate yourself about your health plan benefits and services, including exclusions, and how to obtain these benefits and services;

If you have questions or comments about these rights and responsibilities, feel free to discuss them with us.

Patient/Physician Relationship

The establishment of a patient/physician relationship creates many duties for your doctors to make sure you get the treatment you need. Your enrollment in a healthcare plan, before you have selected your particular physicians, does not establish a patient/physician relationship. Generally speaking, once a patient/physician relationship is established, your doctor has an ongoing responsibility to you until the relationship in terminated. This obligation includes providing "coverage" for you when your doctor is ill, on vacation, or treating other patients. Such coverage is typically provided by other doctors or healthcare professionals who agree to be available to provide care in your doctor's absence.

How can I end the patient/physician relationship?
You can end the patient/physician relationship by telling your doctor that you no longer want to be treated by him or her. As a general rule, a patient/physician relationship is established between you and a physician when the initial history and physical examination is conducted. Depending on the circumstances, the relationship may exist even earlier, such as when a physician agrees by telephone to see you, when you enter the physician's examining room, or when a referral physician gives you an appointment for a consultation.

Can my doctor end the patient/physician relationship?
Yes. The patient/physician relationship can be terminated by your doctor when he or she gives you notice and a reasonable opportunity to find substitute care. A doctor can decide whether he or she will provide services to any particular person. However, there are both legal and ethical constraints on a doctor's discretion. A doctor is not free to refuse a patient merely because a patient is a member of certain groups. It is illegal and unethical to refuse to treat a patient because of the patient's sex, race, color, religion, ancestry, national origin, or physical disability. In addition, a doctor's ability to terminate you as a patient may also be limited by a contract between your doctor and your health care plan or hospital, which requires the doctor to see all patients.

Medical Information Privacy
Timothy Lamb is firmly committed to the protection of your personal health information and has adopted stringent policies and procedures to ensure the privacy of this information. Our "Notice of Privacy Practices" describes how we use, disclose and protect your medical information and lists your rights as a patient to your medical information. A copy is available upon request.

Our policies and procedures are in full compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal regulations established to provide protections for the privacy and security of an individual's health information. To ensure comprehensive, quality care, health care information will be shared among care partners as appropriate.

In addition to protecting the privacy of personal medical information, HIPAA gives patients certain rights regarding their individual health information. Additional information and HIPAA forms are available upon request or through the following government web site: www.hhs.gov/ocr/hipaa.

Signature
We the undersigned have reviewed this agreement and agree that this constitutes the entire agreement and the understanding between both parties.

	Timothy Lamb M.D.
Name of Patient (Print or Type)	Name of Physician (Print or Type)
Signature of Patient	Signature of Physician
Date	Date
Signature of Patient Representative (if applicable)	
Relationship of Patient Representative to Patient	

Internal Medicine Primary Care Physicians
42557 Woodward Ave. Suite 110
Bloomfield Hills Mi 48304-5038
Tel: 248-253-1505
Fax: 248-253-1503

Dr. Timothy Lamb

ACKNOWLEDGMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I read and/ or took receipt of a copy of the Michigan Healthcare Professionals, P.C. Patient Notice of Privacy Practice (effective September 23, 2013).

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Person(s) with whom patient's information may be shared:

Name: _____ Phone Number: _____

Relationship to Patient: _____

Name: _____ Phone Number: _____

Relationship to Patient: _____

Name: _____ Phone Number: _____

Relationship to Patient: _____

Name: _____ Phone Number: _____

Relationship to Patient: _____