Timothy Lamb M.D. New Patient Questionnaire Varsha Revankar M.D.

INTERNAL MEDICINE PRIMARY CARE PHYSICANS

MICHIGAN HEALTHCARE PROFESSIONALS

AFFILIATED WITH SJMO & BEAUMONT

Name: _____ D.O.B.: _____

Email: _____ S.S.N: _____

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: _____

OBGYN: _____

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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? _____

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

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: _____

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? _____

Dr. Timothy Lamb & Dr. Varsha Revankar
IMPCP

Health Management Questionnaire

These are questions your doctor needs answered to better take care of your health.

Name: _____ DOB: _____

Email: _____

If your answer is yes, please specify.

Do you exercise? Yes or No How much: _____

Do you smoke? Yes or No How much: _____

Do you drink? Yes or No How much: _____

Have you fallen in the past year? Yes or No How much: _____

Have you felt depressed in the past year? Yes or No

Have you been to the hospital this year? Yes or No

Date/Where: _____

Have you had your Pneumonia vaccine? Yes or No Date: _____

Which Pneumonia vaccine? Circle One 23 or 13

Have you had your flu vaccine? Yes or No Date: _____

Have you had your COVID vaccine? Yes or No

Manufacturer: _____ Date of 1st shot: _____

Date of 2nd shot: _____

Have you had a colonoscopy/Cologuard? Yes or No Date: _____

Have you had a mammogram? Yes or No Date: _____

Have you had a pap smear? Yes or No Date: _____

Are you on a cholesterol medication? Yes or No Type: _____

Are you on blood pressure medication? Yes or No Type: _____

Do you take aspirin daily? Yes or No

Have you had your eye exam this year? Yes or No Date: _____

Have you had a bone density check? Yes or No Date: _____

Diabetics **ONLY**

Are you a diabetic? Yes or No If yes, answer questions below.

Do you know your last A1C? Date: _____ Result: _____

Do you have diabetes with kidney damage? Yes or No

Socioeconomic Determinants of Health Screening

Patient Name_____

Domain	Question	Circle Response		Check Box if Need to Address/ Urgent?	*(For Office Use Only Community Referra Given*
HealthCare	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?	Yes	No	☐	
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No	☐	
Food	Do you ever eat less than you feel you should because there is not enough food?	Yes	No	☐	
Employment & Income	Do you have a job or steady income?	Yes	No	☐	
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent, or share?	Yes	No	☐	
Utilities	In the past year, have you had a hard time paying your utility company bills?	Yes	No	☐	
Childcare	Does getting child care make it hard for you to work, go to school or study?	Yes	No	☐	
Education	Do you feel like you do not understand information regarding your medical condition?	Yes	No	☐	
Transportation	Is transportation an issue getting to and from doctors appointments?	Yes	No	☐	
Clothing & Household	Do you need assistance obtaining household supplies, for example-clothes, cleaning supplies, shoes, blankets, diapers, toothpaste?	Yes	No	☐	

Patient Signature_____Date_____

Staff Signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF

PATIENT NOTICE OF PRIVACY PRACTICE

I acknowledge that I read and / or received a copy of the Michigan Healthcare Professionals, P.C.
Patient Notice of Privacy Practices effective September 23, 2013.

Date:_____Patient Signature:_____

Patient Printed Name: _____

Internal Medicine Primary Care Physicians

Dr. Timothy Lamb & Dr. Varsha Revankar

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.

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. Patient's 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, coverages, 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.

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.

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

Print Patient's Name: _____

Patient / Guardian Signature: _____ Date: _____

INTERNAL MEDICINE PRIMARY CARE PHYSICIANS

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Internal Medicine Primary Care Physicians. 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 cancel or reschedule and appointment please contact our office as soon as possible and no later than 24 prior to you scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment cancellation/ no show policy below:

- Effective April 12, 2018 any established patient who fails to show up or cancels/reschedules and appointment and has not contacted our office with at least 24 hours' notice will be considered a no show and charged a $20.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $40.00 fee.
- If a third no show or cancellation/reschedule with no 24 hour notice should occur, the patient may be dismissed from Internal Medicine Primary Care Physicians.
- Any new patient who fails to show for their initial visit will be charged $35.00 or 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

Internal medicine Primary care I have read and understand the medical appointment cancellation/no show policy and agree to its terms.

_____ signature (parent/legal guardian) relationship to patient.

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 Varsha Revankar (physician) and _____ (patient).

Physician Commitment to Physician Responsibilities

Varsha Revankar 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. Varsha Revankar 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
Varsha Revankar 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.

	Varsha Revankar 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

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.3

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ Date of Birth: _____

Entity Requested to Release Information:

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.