Commerce Primary Care

Patient Information Sheet

Patient Name: _____

DOB: _____ **Gender:** Male Female **Marital Status:** Single Divorced Married

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Chaldean ☐ Other **DATE OF LAST PHYSICAL (NEW PATIENTS):** _____

Full Address: _____

Primary Phone #: _____ **Alternate Phone #:** _____ **Work Phone #:** _____

Preferred Pharmacy: (Name, City & Street) _____

Emergency Contact: _____ **Emergency Contact Phone #:** _____

Please indicate if there is a family member or friend to whom we are allowed to release or discuss medical information with. I would like to authorize the following person(s) to have access to my medical information:

_____

Primary Insurance:	**Secondary Insurance:**
Company Name:	Company Name:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder:	Policy Holder:
Policy Holder DOB:	Policy Holder DOB:

Preferred Method of Communication:

PLEASE FILL OUT ALL OF THE INFORMATION BELOW & MARK THE BOX WHICH METHOD YOU PREFER*

☐ **Phone Only** Preferred Phone #: _____ Can we leave a voicemail with medical info: **YES** **NO**

☐ **Mail Only** Mailing Address: _____

☐ **Text Message** Preferred Phone #: _____

☐ **Portal (Web)** Speak to front office staff about getting the portal invite sent to your email (Note: must accept invite within 48 hours of receiving to your email)

☐ **Email** E-Mail Address: _____

(Note: cannot email protected health information)

I AUTHORIZE COMMERCE PRIMARY CARE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO COMMERCE PRIMARY CARE FOR SERVICES RENDERED. I AGREE TO PAY MY COPAYS, DEDUCTIBLES AND ANY BALANCE THAT IS DENIED OR DISPUTED BY MY INSURANCE COMPANY.

SIGNATURE: _____ **DATE:** _____

H.I.P.A.A. (Health Insurance Portability & Accountability Act)

ALL PATIENTS

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize **Commerce Primary Care** to release any medical information to any third-party payer, or its representative, which may be responsible for payment in my case. As required by law, such information from my medical record is necessary in order to receive reimbursement for any billings rendered relating to my treatment. This includes alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and information about communicable disease and infection as defined by The Department of Public Health rules (Michigan Public Health Code 1988 Public Act 488) which include venereal disease, tuberculosis, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

Initials:_____

I acknowledge that I have read a copy of this office's *Notice of Privacy Practices Form* that is displayed and may receive a copy if requested.

Initials:_____

I understand that I am financially responsible to pay deductibles, co-pays or any other balance that may not be paid by my insurance.

Initials:_____

MEDICARE PATIENT'S ONLY

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and Medigap benefits be made either to me or on my behalf to this provider for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents or Medigap insurer any information needed to determine these benefits or the benefits payable to related services.

Signature: _____
(Patient or Patient's Representative)

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

Past Surgical History: Please circle "Y" or "N" for any surgeries you have had in the past

Appendectomy	Y	N	Fracture Repair	Y	N	Pacemaker Implant	Y	N
Breast Biopsy	Y	N	Gallbladder Removal	Y	N	Prostate Biopsy	Y	N
Cardiac Catherization	Y	N	Hemorrhoid Repair	Y	N	Spleen Removal	Y	N
Cardiac Stent	Y	N	Hernia Repair	Y	N	Thyroid Removal	Y	N
Cataract Surgery	Y	N	Hysterectomy	Y	N	Tonsil Removal	Y	N
Coronary Artery Bypass	Y	N	Knee Surgery	Y	N	Valve Replacement	Y	N
C-Section	Y	N	Mastectomy	Y	N	Vasectomy	Y	N
Dilation & Curretage (D&C)	Y	N	Melanoma removal	Y	N	Wisdom	Y	N

Please list any other surgeries you have had in the past:

_____

_____

_____

Medications: Please list any medications you are currently taking (prescription, vitamin, herbal etc.)

Name	Dose	Schedule
1.		
2.		
3.		
4.		
5.		

Name	Dose	Schedule
6.		
7.		
8.		
9.		
10.		

Please list all allergies you may have:

_____

_____

Social History:

Do you use tobacco? ___Yes ___No ___Formerly (year quit_____)

- If yes, how much? _____per day For how long_____

Do you drink alcohol ___Yes ___ No

- If yes, how often? ___socially ___moderately ___heavy

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

Past Medical History: Please circle "Y" or "N" for the following medical conditions/history that pertains to **YOU**:

Anemia	Y	N	Fibromyalgia	Y	N	Liver Disease	Y	N
Arthritis	Y	N	Hearing Problems	Y	N	Migraine/Headache	Y	N
Asthma	Y	N	Heart Attack	Y	N	Osteoporosis	Y	N
Bladder Disorder	Y	N	Heart Disease	Y	N	Pneumonia	Y	N
Cancer-Type:	Y	N	Heartburn/GERD	Y	N	Prostate Disorder	Y	N
COPD	Y	N	Hepatitis	Y	N	Seizures	Y	N
Coronary Artery Disease	Y	N	Hernia	Y	N	Stroke	Y	N
Depression/Anxiety	Y	N	High Cholesterol	Y	N	Thyroid Disorder	Y	N
Diabetes: Type 1 or Type 2	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	HIV/AIDS	Y	N	Ulcers	Y	N

Please list any other medical history not listed above:

_____

_____

_____

Past Medical History: Please circle "Y" or "N" for the following medical conditions/history that pertains to **YOUR FAMILY**:

Anemia	Y	N	Fibromyalgia	Y	N	Liver Disease	Y	N
Arthritis	Y	N	Hearing Problems	Y	N	Migraine/Headache	Y	N
Asthma	Y	N	Heart Attack	Y	N	Osteoporosis	Y	N
Bladder Disorder	Y	N	Heart Disease	Y	N	Pneumonia	Y	N
Cancer-Type:	Y	N	Heartburn/GERD	Y	N	Prostate Disorder	Y	N
COPD	Y	N	Hepatitis	Y	N	Seizures	Y	N
Coronary Artery Disease	Y	N	Hernia	Y	N	Stroke	Y	N
Depression/Anxiety	Y	N	High Cholesterol	Y	N	Thyroid Disorder	Y	N
Diabetes: Type 1 or Type 2	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	HIV/AIDS	Y	N	Ulcers	Y	N

Please list any other medical history not listed above:

_____

_____

_____

COMMERCE PRIMARY CARE
8800 Commerce Road
COMMERCE, MI 48382

248.363.7500
248.363.7700 fax

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Commerce Primary Care to obtain and/or disclose any health information with other physicians/facilities that I may be referred to, as well as physicians/facilities I have been to in the past.

Patient's Name: _____D.O.B._____

Your previous doctor's name and phone or fax number:

_____

Specific description of information to be released:

LAST 3 YEARS OF: **LABS, CONSULTATIONS, & DIAGNOSTICS (XRAYS, ETC.)**

Purpose of the use or disclosure: continuity of medical care.

The Patient or Patient's Representative must read and initial the following statements:

I understand that:

a.) My health care and the payment for my health care will not be affected if I do not sign this form

b.) I may see and/or have a copy of the information described on this form and the form itself after I sign it.

c.) I may revoke this authorization at any time by notifying the providing organization in writing. However, it has no effect on any actions they took before they received the revocation.

_____ _____

***Signature* of Patient or Patient's Representative** Date:

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
HOWEVER, THIS WILL DELAY OUR EFFORTS TO RETREIVE RESULTS, ETC.

Financial Policy

Thank you for choosing Commerce Primary Care as your healthcare provider. We are committed to providing you with the best possible medical care. The following information outlines your financial responsibilities related to payment for professional services:

We participate in most major health plans. Our office will submit claims on your behalf for services rendered. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary insurance has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you fail to provide the information, claims will not be paid and will be billed to you. Please remember that insurance is a contract between the patient and the insurance company.

Auto Injury/Workers' Comp Claims. Please inform the front desk staff if your visit is related to an auto accident or workers' comp injury. We must have your auto/workers' comp insurance information in order to properly bill the visit.

If you do not have health insurance,payment for your office visit and any additional procedures must be paid at the time of service. Payment for telehealth services will be collected by credit card when the appointment is scheduled. We will also ask that you read and sign our self-pay policy. Self-pay patients will not be allowed to carry a balance. We will not allow patients with insurance to self-pay. This applies only to established patients. We do not accept new self-pay patients.

We must have a current insurance card on file. This is to ensure that the information we have on file is correct, and that your plan is active and one in which we participate. If you fail to provide us with the correct insurance information, you will be responsible for the charges. If you change insurance plans, it is your responsibility to notify our office. For patients with Medicare, we must have a copy of your Original Medicare card, even if you have a Medicare Advantage plan with another company. Please provide any prescription cards as well.

Understand your insurance benefits. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. Medical services that are not covered, out-of-network, or not medically necessary will be your responsibility. Before having any recommended tests and procedures (including labs), we suggest you verify coverage with your insurance company to avoid any surprise bills. Once appointments are made for such services, you must provide our office with the appointment date, doctor's/facility name and NPI, and the reason for visit so we are able to do the proper paperwork in a timely manner. Please leave detailed information on our voicemail, prompt #4.

Patients are responsible for copays, coinsurance, deductibles and non-covered services. Insurance companies require us to collect copays at the time of service. Additionally, you may have coinsurance and/or deductible amounts required by your insurance plan. Any outstanding balance on your account, after adjusting for all your insurance's responsibilities, will be billed to you. We also encourage you to read the Explanation of Benefits (EOB) from your insurance company.

Every patient at Commerce Primary Care should strive to follow our key policies designed to support a healthy and respectful treatment environment for all patients.

As a patient you have the right to:

- Be treated with respect & dignity in every situation.
- Receive information concerning your illness or medical condition and participate in the assessment of your needs and treatment
- Receive appropriate guidance, support and supervision from our staff
- Expect that all communications and records pertaining to your care will be kept confidential

As a patient you are expected to:

1. Keep scheduled appointments or notify staff when you are unable to do so (see CPC no show & late policy)
2. Sign a Controlled Substance Agreement (CSA) with our office for any narcotic or amphetamine prescription
3. Comply with reasonable provider recommendations. These recommendations are based on established healthcare guidelines and followed for your welfare and safety. You may refuse to comply with such recommendations, but if your provider feels such refusals are putting your health at risk this may create a liability for the practice and thus we maintain the right to dismiss you for medical non-compliance.
4. Keep up to date on your billing account: Paying co-pay at the time of visit, mailing in payments when they are due, if unable to pay a balance you must sign a payment plan agreement.
    a. **Payment plans:** You must make a payment before you're seen. If you cannot, your appointment will be canceled. If you are delinquent on a payment plan that has been set up by one of our billers and cannot pay at the time of visit, a dismissal may be warranted.
    b. Please adhere to Commerce Primary Care Financial Policy for detailed rules and regulations.
5. Treat commerce Primary Care staff with respect and dignity in every situation. There is a zero tolerance policy for any verbal or physical abuse by a patient. This will lead to immediate dismissal from our practice. You will be sent a letter of dismissal and given 30 days of emergency based care only to allow for time to transfer to another Primary Care facility.

If you have an HMO plan such as BCN or HAP, you are responsible for contacting the insurance company and updating **the primary care physician (PCP)** to Dr. Samuel Jonnalagadda or Dr. Alka Jain. Even if you see another medical professional in our office, Dr. Sam or Dr. Jain must be the PCP. You will be responsible for the charges if this is not done prior to your appointment. We will not schedule a new patient with an HMO plan until we can verify the PCP.

It is the policy of Commerce Primary Care to treat all patients fairly and equally regarding account balances. The practice will not waive, fail to collect, or discount copays, coinsurance, deductibles or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with insurance companies.

Balances are due within 30 days of the date the statement is issued. Statements will be issued after the insurance company pays its portion of the claim. We accept cash, check, money order, and credit card (VISA, Mastercard, American Express and Discover). Returned checks will incur a $25 service charge. Secure online payment may be made with a credit card using the 'Quickpay Portal' that is noted on the statement along with the corresponding QuickPay code.

Patients with a past due balance of 90 days or more are required to make payment in full before future services are rendered or be on a payment plan. Failure to pay your balance may affect your ability to receive future medical care from Commerce Primary Care. We do understand that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly. An interest-free payment plan is available in those situations. If you choose a payment plan, a credit card must be provided to assure regular monthly payments. Otherwise, if your account remains past due you may be dismissed from this practice. If this occurs, you will be notified via US Mail that you have 30 days to find alternate medical care. During that 30-day period, our physicians will treat you on an emergency basis only.

No-Show Policy. Please be courteous and notify us immediately if you cannot keep your scheduled appointment. This will allow another patient to utilize that time slot. If you do not notify us, you will be charged a $25 no-show fee. This fee is not covered by your insurance.

Please note that **lab services performed in our office are billed by Quest Diagnostics**, not Commerce Primary Care. Any issues with lab bills should be addressed with Quest and/or your insurance company first. Drug testing is not performed by Quest Diagnostics. We use an outside lab for drug testing services.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. A copy of this policy will be provided to you upon request.

I have read and understand the financial policy and agree to abide by its guidelines.

Signature of Patient or Responsible Party Date

_____ _____

***Signature* of Patient or Patient's Representative** Date:

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

Dear Patient and Family,

At our office, we are preparing to receive recognition as an office that provides care according to the standards of a Patient Centered Medical Home (PCMH). An office designated as a PCMH, provides comprehensive, coordinated health care to patients at all stages of their life. It is a health care partnership developed between the patient and his/her personal physician that may seem different to you.

As a valued patient, we are excited to discuss this rewarding approach to health care right here in our office with no additional cost or inconvenience to you. In fact, we think you will be very pleased with some of the patient friendly features that will be available to you now and in the future.

Please take a few moments to review the Patient-Doctor Partnership Brochure. It describes each of our roles in caring for you. This is an important feature of our office. As partners in your health care we look forward to discussing this information with you and answering any questions you may have.

Sincerely,

Commerce Primary Care

Commerce Primary Care

Samuel Jonnalagadda, M.D.
Alka Jain, M.D.
Jessica Graham– N.P.-C.
Lana Elia, N.P.-C.
Kathy Farquhar, P.A.-C.

8800 Commerce Road.
Commerce Twp., MI 48382
Phone: (248) 363-7500
Fax: (248) 363-7700

Same day appointments are available!

After Hours Emergency

For after hours emergencies please call our main office where you will be directed to our after hours on call provider.

To insure comprehensive, quality care for our patients, this office will share patient health information with other providers involved in their care as appropriate and necessary.

Patient Doctor Partnership

Oakland Physician Network Services

Patient- Doctor Partnership:

The health and wellness of our patients is a top concern of this office.

Providing the best possible care to every patient is our primary goal.

The only way we can meet this goal is if
I, *your doctor*,
the office staff

and

you, *my patient*,
work together.

This concept is called the
Patient Centered Medical Home.

Doctor Responsibilities:

Explain diseases, treatments, and results in an easy-to-understand way.

Listen to my patients' feelings and questions help them make decisions about their care.

Keep 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.

To care for you to the best of my abilities based on my understanding of current medical methods available.

Give my patients clear directions about medicines and other treatments.

Send my patients to trusted experts, if needed.

End every visit with clear instructions about expectations, treatment goals, and future plans.

Patient Responsibilities:

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 well being.

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.

End every office visit with a clear understanding of your doctor's expectations, treatment goals, and future plans for you.