Primary Care Specialists, P.C.

Elise Murray, D.O.
Lisa O'Neil, D.O.

33611 Warren Road
Westland, MI 48185
(734) 641-8900
(734) 641-8970 Fax

Dear New Patient,

Thank you for choosing Primary Care Specialists, P.C. as your Internal Medicine Office. We welcome you to our facility. Please read the following information so your New Patient appointment may be a pleasant experience and run smoothly.

Enclosed in the packet you will find:

- New Patient Information Sheet
- Medical History Form
- HIPAA Form
- Notice of Privacy Practices Form (for you to keep)
- Authorization for Medical Treatment/Financial Responsibility Form
- Patient-Doctor Partnership Form
- Records of Release Form

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT.

This will expedite the check in process and ensure all the necessary paperwork is filled out and received, prior to seeing the doctor.

Please bring the following with you to your appointment:

- The packet of information, filled out completely
- Your Insurance Card
- Your Driver's License or Photo ID
- Any medications you are taking – **PLEASE BRING THEM IN ORIGINAL BOTTLES**

Welcome! Thank you for choosing Primary Care Specialists.

Dr. Elise Murray and Dr. Lisa O'Neil

PATIENT INFORMATION (PLEASE PRINT)

Name of Patient_____ Date_____

Home Address_____

Home Telephone_____ Work/Cellular Telephone_____

City_____ State_____ Zipcode_____

Date of Birth_____ Sex M F Single / Married / Widow / Divorced Social Security Number_____

Person Financially Responsible for Patient_____ Relationship_____

Emergency Contact_____ Relationship_____ Telephone_____

Whom May We Thank for Referring You_____

PRIMARY INSURANCE

Name of Insured_____ Relationship to Patient_____

Address (if different from patient)_____

Insured's Date of Birth_____ Social Security Number_____

Insured's Employer_____ Work Telephone_____

Insurance Plan Name_____

Policy Number_____ Group Number_____

Co-Pay_____ Deductible_____ Type of Plan Medicare HMO PPO Commercial

Are you familiar with coverage limitations of your plan?_____

SECONDARY INSURANCE

Name of Insured_____ Relationship to Patient_____

Address (if different from patient)_____

Insured's Date of Birth_____ Social Security Number_____

Insured's Employer_____ Work Telephone_____

Insurance Plan Name_____

Policy Number_____ Group Number_____

Co-Pay_____ Deductible_____ Type of Plan Medicare HMO PPO Commercial

Are you familiar with coverage limitations of your plan?_____

AUTHORIZATION FOR TREATMENT

I authorize Name of Physician to provide medical treatment for myself or _____ (name of patient).

Signature_____ Relationship to Patient_____

ASSIGNMENT OF MEDICARE BENEFITS	**ASSIGNMENT OF INSURANCE BENEFITS**
I request that payment of authorized Medicare benefits be made to me or on my behalf to Primary Care Specialists, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it. Signed_____ Date_____	I request that payment of authorized insurance benefits be made to me or on my behalf to Primary Care Specialists, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the _____ (name of insurance company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it. Signed_____ Date_____

ADULT MEDICAL HISTORY

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE ALL INFORMATION WILL BE KEPT CONFIDENTIAL

PATIENT IDENTIFICIATION INFORMATION

LAST NAME FIRST NAME MIDDLE NAME DATE OF BIRTH AGE SEX (M OR F)

ADDRESS: NUMBER AND STREET CITY STATE ZIP HOME TELEPHONE #

OCCUPATION EMPLOYER NAME BUSINESS TELEPHONE #

EMERGENCY CONTACT PERSON NAME RELATIONSHIP HOME TELEPHONE #

EMERGENCY CONTACT PERSON ADDRESS CITY STATE ZIP BUSINESS TELEPHONE #

CURRENT MEDICAL PROBLEMS

IF YOU ARE BEING TREATED FOR ANY OTHER ILLNESSES OR MEDICAL PROBLEMS BY ANOTHER PHYSICIAN, PLEASE DESCRIBE THE PROBLEMS AND INDICATE THE NAME OF THE PHYSICAN TREATING YOU.

ILLNESS OR MEDICAL PROBLEM	PHYSICIAN TREATING YOU

ILLNESS AND MEDICAL PROBLEMS

PLEASE MARK WITH AN (X) ANY OF THE FOLLOWING ILLNESSES AND MEDICAL PROBLEMS YOU HAVE OR HAVE HAD AND INDICATE THE YEAR WHEN EACH STARTED. IF YOU ARE NOT CERTAIN WHEN AN ILLNESS STARTED, WRITE DOWN THE APPROXIMATE YEAR.

ILLNESS	X	YEAR	ILLNESS	X	YEAR	ILLNESS	X	YEAR
EYE OR EYE LID INFECTION			HEART MURMUR			EPILEPSY		
GLAUCOMA			OTHER HEART CONDITION			HEAD INJURY		
OTHER EYE PROBLEM			STOMACH/DUODENAL ULCER			STROKE		
DEAFNESS			DIVERTICULOSIS			CONVULSIONS, SEIZURES		
BRONCHITIS			COLITIS			ARTHRUITIS		
EMPHYSEMA			GOUT			CANCER OR TUMOR		
PNEUMONIA			YELLOW JAUNDICE			BLEEDING TENDENCY		
ALLERGIES OR ASTHMA			LIVER TROUBLE			DIABETES		
TUBERCULOSIS			HEPATITIS			PSORIASIS		
OTHER LUNG PROBLEMS			HERNIA			MENTAL ILLNESS		
HIGH BLOOD PRESSURE			HEMMORRHOIDS			OTHER		
HEART ATTACK			KIDNEY OR BLADDER DISEASE			THYROID DISEASE		
HIGH CHOLESTEROL			KIDNEY STONE					
ARTERIOSCLEROSIS			MIGRAINE HEADACHE					

HOSPITALIZATIONS

YEAR	OPERATION OR ILLNESS	HOSPITAL AND CITY

ILLNESS AND MEDICAL PROBLEMS

PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING, INCLUDE THOSE YOU BUY WITHOUT A DOCTOR'S PRESCRIPTION (SUCH AS APRIRIN, VITAMINS, ETC.)

1	5	9
2	6	10
3	7	11
4	8	12

ALLERGIES AND SENSITIVITIES

LIST ANYTHING THAT YOU ARE ALLERGIC TO SUCH AS CERTAIN FOODS, MEDICATIONS, DUST, CHEMICALS OR SOAP, HOUSEHOLD ITEMS, POLLEN, BEE STINGS, ETC., AND INDICATE HOW EACH AFFECTS YOU

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

SOCIAL / PERSONAL HISTORY

CURRENTLY LIVE ___ALONE ___WITH FAMILY ___WITH FRIENDS ___WITH SIGNIFICANT OTHER

MARITAL STATUS ___MARRIED ___DIVORCED ___SEPARATED ___WIDOWED ___NEVER MARRIED

LAST GRADE COMPLETED IN SCHOOL_____

HAVE YOU EVER BEEN REJECTED FOR HEALTH REASONS BY THE MILITARY, AN EMPLOYER OR AN INSURANCE COMPANY? ___YES ___NO IF YES, PLEASE EXPLAIN_____

SMOKING HISTORY DO YOU CURRENTLY SMOKE? ___YES ___NO HOW MUCH PER DAY?_____

HOW MANY YEARS HAVE YOU SMOKED?_____ ARE YOU A FORMER SMOKER? ___YES ___NO

WHEN DID YOU QUIT?_____ DO YOU CHEW TOBACCO? ___YES ___NO DO YOU SMOKE ANYTHING ELSE?____

CONSUMPTION OF ALCOHOLIC BEVERAGES? ___YES ___NO AMOUNT_____

DO YOU USE DRUGS? ___YES ___NO TYPE_____ FREQUENCY_____

DO YOU EXERCISE REGULARLY? ___YES ___NO HOW OFTEN?_____

DO YOU WEAR SEATBELTS? ___YES ___NO

ARE THERE ANY HEALTH RISKS INVOLVED IN YOUR JOB, HOME ENVIRONMENT OR ACTIVITIES? ___YES ___NO

IF YES, PLEASE EXPLAIN_____

FAMILY HEALTH

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR FAMILY				HAVE ANY BLOOD RELATIVES HAD ANY OF THE FOLLOWING DISEASES? IF SO, INDICATE RELATIONSHIP BY PLACING AN X IN THE APPROPRIATE BOX				
RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FATHER	MOTHER	SISTER	BROTHER
FATHER				HEART DISEASE				
MOTHER				HIGH BLOOD PRESSURE				
BROTHER(S)				CANCER				
				DIABETES				
SISTER(S)				BLOOD DISEASE				
				EPILEPSY				
SPOUSE				RHEUMATOID ARTHRITIS				
CHILDREN				GOUT				
				GLAUCOMA				
				TUBERCULOSIS				

SYMPTOM REVIEW

PLEASE CIRCLE EACH ITEM THAT YOU NOW HAVE WHERE APPLICABLE, PLEASE FILL IN ADDITIONAL INFORMATION

GENERAL	WEAKNESS CHILLS CHANGE IN WEIGHT, APPETITE, OR SLEEPING HABITS FATIGUE NIGHT SWEATS
SKIN	ITCHING CHANGE IN COLOR RASH EASY BRUISING
NERVOUS SYSTEM	HEADACHE DOUBLE VISION NUMBNESS DIZZINESS MUSCLE WEAKNESS LOSS OF COORDINATION
LUNGS	COUGH SHORTNESS OF BREATH POSITIVE TB TEST WHEEZING SPITTING UP BLOOD LAST CHEST X-RAY DATE_____
HEART	CHEST PAINS TROUBLE BREATHING AT NIGHT EASY FATIGUE PALPITATIONS (HEART POUNDING) TROUBLE CLIMBING STAIRS ANKLE SWELLING
GASTROINTESTINAL	STOMACH PAIN / ABDOMINAL PAIN DIFFICULTY SWALLOWING VOMITTING CHANGES IN BOWEL HABITS INDIGESTION / HEART BURN BLOOD IN STOOLS
URNINARY	PAIN IN URINATION FREQUENT URINATION DIFFICULTY STARTING URINATION BLOOD IN URINE PREVIOUS INFECTIONS
EYES	GLASSES / CONTACTS EXCESSIVE TEARING DATE OF LAST EXAM_____ EYE PAIN BLURRING OR SPOTS
EARS	LOSS OR DECREASED HEARING RINGING DRAINAGE
NOSE/THROAT/SINUSES	NOSEBLEED HOARSENESS SWELLING SORE TROAT POST NASAL DRIP
MOUTH	DENTURES TOOTHACHE BLEEDING GUMS DATE OF LAST EXAM_____
JOINTS & BACK	PAIN STIFFNESS SWELLING DEFORMITY
MUSCLES	PAIN TWITCHING WEAKNESS
ENDOCRINE	EXCESSIVELY HOT EXCESSIVELY COLD ALWAYS HUNGRY ALWAYS THIRSTY
PSYCHOLOGICAL	NERVOUSNESS UNABLE TO SLEEP MEMORY LOSS DEPRESSION NIGHTMARES
IMMUNIZATIONS	TETANUS DATE_____ INFLUENZA DATE_____ SHINGRIX DATE_____ PNEUMOCOCCAL DATE_____ MMR (MEASLES, MUMPS, RUBELLA)_____ PREVNAR 13 (PNEUMONIA)_____
MALE	HERNIA PAIN IN TESTICLES SEXUAL DIFICULTIES DISCHARGE FROM PENIS SEXUALLY TRANSMITTED DISEASE
FEMALE	VAGINAL ITCHING OR BURNING PREGNANCY, NUMBER_____ VAGINAL DISCHARGE MISCARRIAGES OR ABORTIONS NUMBER_____ PROBLEMS WITH MENSTRUAL PERIODS LIVE BIRTHS, NUMBER_____ LAST MENSTURAL PERIOD DATE_____ PROBLEMS DURING PREGNANCY LAST PAP SMEAR DATE_____ LUMPS IN BREAST METHOD OF CONTRACEPTION_____ DISCHARGE FROM NIPPLE SEXUALLY TRANSMITTED DISEASE LAST MAMMOGRAPHY DATE_____ SEXUAL DIFFICULTIES

SIGNS & SYMPTOMS NOT COVERED ABOVE (ADDITIONAL SPACE ON BACK)

_____

_____

_____

PATIENT SIGNATURE_____ DATE_____

PHYSICIAN SIGNATURE_____ DATE_____

Patient-Doctor Partnership Agreement

Welcome to your Patient-Centered Medical Home. Thank you for choosing to partner with our medical practice for patient-centered care. We appreciate the trust and confidence you have placed in us for your care.

PRIMARY CARE RESPONSIBILITIES

- **Listen** to your health concerns.
- Provide **information** on chronic conditions and prevention programs.
- Provide **flexible** and expanded office hours, schedule appointments within a reasonable time, and see patients as closely as possible to scheduled appointment time.
- Provide telephone **availability** to reach a clinical decision-maker for communication 24 hours per day, 7 days per week.
- **Coordinate** care provided by my practice team, other clinicians and health care institutions effectively to avoid duplication, delay and error.
- **Communicate** test and treatment results promptly and correctly.
- Provide information and advice regarding **preventative care,** maintaining wellness, self-management direction and counseling.
- Provide **reminders** for follow up and preventative care.
- Maintain clinical information that allows us to participate in the development and maintenance of health records and **patient registries,** while protecting privacy and confidentiality.

PATIENT RESPONSIBILITIES

- **Communicate** openly
- **Participate** with your health care team in the development of treatment plans to improve your health
- Provide Health Care Team with **feedback** regarding action and treatment plans.
- **Respect** the time of other by being on time for appointment and procedures.
- **Schedule and attend** appointments at intervals suggested by Health Care Team.
- **Involve yourself** in Physician's and other health care professionals' recommendations with respect to maintenance or improvement of your health and wellness.
- Participate in **action planning** and goal setting with respect to maintenance or improvement of your health and wellness.
- Participate in developing and maintaining a **comprehensive health record** by authorizing delivery and circulation of clinical information to and from clinicians and health care institutions.

AFTER HOURS CARE

- Please utilize our office during hours of operation but we understand that some medical complaints may occur after hours so we would recommend you call us first or go to an urgent care if needed.

_____

Date

_____

Patient Name

_____

Patient / Guardian Signature

Primary Care Specialists, P.C.

Lisa O'Neil, D.O. & Elise Murray D.O.

33611 Warren Road, Westland, MI 48185

Phone (734) 641-8900

Primary Care Specialists, P.C.
33611 Warren Road
Westland, MI 48185

Authorization and Agreement of Medical Treatment
Insurance Benefits and Financial Responsibility

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Elise Murray, D.O. and/or Lisa O'Neil, D.O. or their associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow up examinations to check abnormalities found and treated, lies with me and not my physician, thereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Elise Murray, D.O. and/or Lisa O'Neil, D.O. or their associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatment that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

1. Payment is due at the time of service. We accept cash, checks, and credit cards.

2. All co-payments, deductibles and non-covered services must be paid in full at the time of service.

3. A schedule of fees for our service is available at the reception desk. Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance are your responsibility.

4. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware of your plan requirements.

5. Your doctor is here to manage your medical care. The Physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial difficulties with the business office staff. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.

6. During a well-physical exam, new or acute complaints cannot be addressed, they will require a separate visit. Insurance companies will allow only one type of visit be billed on the same day.

7. Refills for medications are performed at appointments. We discourage refill requests by phone to ensure accuracy of medications.

8. Prescriptions for controlled substances, which includes pain medications, are prescribed and written during appointments only. A signed pain management contract is required by the patient and doctor.

9. Our office may request your email to allow an invitation to our patient portal and email reminders. We urge each patient to access our patient portal to access their private health information. Patients may also send non-urgent requests via the patient portal.

I have read the above Acknowledgement and Agreements and fully understand the same.

Patient Name (Print) _____

Signature of Patient or Guardian_____ Date_____

Relationship to Patient_____ Witness_____ Date_____

Primary Care Specialists, P.C.

Elise Murray, D.O.
Lisa O'Neil, D.O.

33611 Warren Road
Westland, MI 48185
(734) 641-8900
(734) 641-8970 Fax

LATEX ALLERGIES

Latex allergies can be deadly. Latex has been known to cause anaphylactic shock and subsequently death. If someone has experienced itching and burning after coming in contact with any rubber substances, they would be well advised to tell their doctor that they might be allergic to latex and as his or her to take the appropriate precautions. Allergic reaction to latex can include difficulty breathing, wheezing, bronchospasm, tachycardia, cardiovascular collapse, vomiting, swelling, puffiness, rash, blisters, itchiness and hives. If you know you have an allergy to latex, we advise you wear a Medical Alert Bracelet.

Please mark the appropriate box below indicating whether you DO or DO NOT have a latex allergy.

_____ I DO have a latex allergy

_____ I DO NOT have any known allergies to latex

Patient Signature:_____ Date:_____

HIPAA PRIVACY NOTICE

I, _____, (patient) do hereby authorize the physicians and staff of Primary Care Specialists, P.C. to discuss and release the results of any testing that I have done with the following people:

_____

_____

Patient Signature:_____ Date:_____

Please request a copy of the HIPAA Privacy Policy if you are not familiar with this policy.

HIPAA PRIVACY NOTICE RECEIVED

ACKNOWLEDGEMENT:

I acknowledge that I have received the Notice of Privacy Practice given upon request.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:_____

PATIENT E-MAIL:_____

Primary Care Specialists, P.C.
Dr. Lisa O'Neil, D.O.
Dr. Elise Murray, D.O.

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: APRIL 14, 2003
REVISION DATE: JANUARY 06, 2014

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

As required by law, this Notice of Privacy Practices is being provided to you in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we will protect the privacy of health information and how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes permitted by law. Your "Protected Health Information" or (PHI) means any of your written or verbal health information that is created or received by your health care provider. This may relate to your past present or future physical or mental health or condition.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Requirement for Written Authorization: We will generally obtain your written authorization before using your health information or sharing it with others outside our facility.

Exceptions to Written Authorization Requirements: There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

Treatment, Payment, and Health Care Operations

We may use your health information or share it with others in order to treat your condition, obtain payment for treatment, and run our health care operations.

Treatment: We may share your health information with other health care providers who are involved in your health care needs and physicians to whom you have been referred for further health care treatment.

Payment: We may use your health care information or share it with others so that we may obtain payment for health care services. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment. We may share your information with other health care providers and payors for their payment activities.

Health Care Operations: We may use your health information or share it with others in order to conduct our health care operations. We may share your health information with other health care providers and payors for certain health care operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

Appointment Reminders, Treatment Alternatives, or Distribution of Health-Related Benefits and Services: In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for services at our facility. We may also use your health information in order to recommend possible treatment alternatives or services to you.

Treatment Alternatives: We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services and Reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Business Associates: We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our health care operations. This may be a billing company to obtain payment, accounting or law firm to obtain professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract that requires our business associate to protect the privacy of your health information.

USES AND DISCLOSURES BEYOND TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PERMITTED WITHOUT AUTHORIZATION OR OPPORTUNITY TO OBJECT

Federal privacy rules allow us to use your health information and share it with others in order to treat you in an emergency or to meet public need. We will not be required to obtain your written authorization or provide you with an opportunity to object before we use or disclose your health information for the following:

- As Required By Law
- Public Health Activities
- Victims of Abuse, Neglect or Domestic Violence
- Health Oversight Activities
- Law Enforcement Purposes
- For Research Purposes
- To Advert a Serious and Imminent Threat to Health or Safety
- National Security and Intelligence Activities or Protective Services
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Military and Veterans

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION REQUIRING AUTHOIRZATION

Primary Care Specialists cannot and will not use or disclose your health information without your written authorization for any reason except those described in this notice. In the event you choose to transfer your records to another person or organization, your written authorization will be required when completing an authorization form. If you provide us with written authorization, you may revoke or cancel that written authorization at any time, except to the extent that we have already relied upon it. If you revoke the authorization, we will no longer use or disclose your health information for reasons already covered by your written authorization. Your revocation will not affect any uses or disclosures we have already made prior to the date we receive notice of cancellation. To revoke a written authorization, please write to Primary Care Specialists, at the address listed at the end of this notice.

YOUR RIGHTS AND YOUR RECORDS

You have the right to request and obtain a copy, from our facility in a timely manner of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This may include medical and billing records

RESPONSE TIME

We ordinarily will respond to requests for copies within 30 days. If we need additional time to respond to a request for copies, we will notify you in writing within the timeframe above to explain the reason for the delay.

RIGHT TO NOTICE OF BREACH OF UNSECURED HEALTH INFORMATION

We are required by law to maintain the privacy of your health information, to provide you with this Notice containing our legal duties and privacy practices with respect to your health information and to abide by the form of the Notice. It is our facilities policy to safeguard your health information so as to protect the information from those who should not have access to it. If for some reason we experience a breach of your unsecured health information, we will notify you of the breach.

MISCELLANEOUS

HOW SOMEONE MAY ACT ON YOUR BEHALF

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

HOW TO OBTAIN A COPY OF REVISED NOTICE

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices, and the revised Notice will apply to all of your health information. You may obtain a revised copy of the Notice at the front desk or by calling our office. The effective date of the Notice will always be noted on the cover and on the back page of this Notice. We are required to abide by the terms of the Notice that are currently in effect.

HOW TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, please contact the Privacy Officer in writing by using the contact information below. We encourage you to express your concerns regarding the privacy of your Health Information.

No one will retaliate or take action against you for filing a complaint.

Primary Care Specialists, P.C.
33611 Warren Road
Westland, MI 48185
Attn: Privacy Officer

The Privacy Officer can be contacted by phone at **(734) 641-8900**

Effective Date: April 14, 2003
Revision Date: January 06, 2014

_____
Patient First & Last Name

_____
Patient Date of Birth

_____
Patient Primary Care Physician

Assessment for Social Needs

Primary Care Specialists, P.C.
33611 Warren Road
Westland, MI 48185

_____
Today's Date

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in times of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please Answer the following questions:	Yes	No	Decline to Answer
In the past month, did poor health keep you from doing your usual activities, like work, school, or a hobby?	☐	☐	☐
In the past 12 months, was there a time when you needed to see a doctor but could not because it cost too much?	☐	☐	☐
In the past 12 months, did you ever eat less than you needed to because there was not enough food?	☐	☐	☐
Is it hard to find work or another source of income to meet your basic needs?	☐	☐	☐
Are you worried that in the next 2 months, you may not have housing?	☐	☐	☐
In the past 12 months, have you had a hard time paying your utility company bills?	☐	☐	☐
Do you need help finding or paying for care for loved ones? For example, childcare or day care for an older adult.	☐	☐	☐
Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?	☐	☐	☐
In the past 12 months, have you had trouble getting to school, work, or the store because you do not have a way to get there?	☐	☐	☐
Do you ever feel unsafe in your home or neighborhood?	☐	☐	☐
Over the last 2 weeks, have you had a great deal of stress or felt overwhelmed?	☐	☐	☐
Over the last 2 weeks, have you felt a lot of anxiety or scared?	☐	☐	☐
Over the last 2 weeks, have you felt depressed or very sad?	☐	☐	☐
***If you answered yes, would you like to receive assistance with any of these needs?**	☐	☐	☐
***Are any of your needs urgent? For example, I need food/shelter for tonight.**	☐	☐	☐

FOR OFFICE STAFF ONLY: **PRIMARY INSURANCE, MEMBER ID**_____

Is patient being provided care management or care coordination services?			
Referrals	Due Date/Follow-Up		
1.			
2.			

Patient Health Questionnaire (PHQ-9)

Patient Name:_____ Date:_____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the last 2 weeks how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				
THIS ROW FOR DOCTOR'S USE ONLY SCORE:	0	1	2	3
(add columns)	+	+	+	
TOTAL SCORE:	=			
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				

PRIMARY CARE SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____

From:_____ To:_____

_____ _____

_____ _____

_____

SPECIFIC INFORMATION TO BE RELEASED:

_____Entire Medical Record Record of Care From_____to_____

Other: _____

_____

_____

Excluding:

_____Communicable disease and infection information as defined by statue of MI Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis B, HIV, AIDS and AIDS related complex.

_____Alcohol and/or drug abuse treatment information protected under 42 Code of Federal Regulations, Part 2.

_____Mental health treatment records, psychological services and social services information.

_____

FOR THE SPECIFIC PURPOSE OF:

_____

_____

I understand this release is effective until _____, but I may revoke my authorization at any time by providing written notice to the above named party. Any written statement to revoke authorization will not be retroactive.

I further understand that PCS will not condition treatment based on providing a signed authorization form.

DATE: _____ _____
(Signature of Patient of Legal Representative)

_____ _____
(Signature of Witness) (Relationship, if other than patient)