



Patient Provider Partnership for Specialist Care

At **Institute of Neuromuscular Medicine**, our goal is to provide you with the highest standard of specialty care that we have been entrusted with by your Primary Care Physician. Your care will be coordinated with your Primary Care Physician who acts as your Patient Centered Medical Home (PCMH). Below are some guidelines to make the best of this partnership:

This means that our practice will make every effort to:

- Schedule your appointment as soon as possible keeping in mind the goals and recommendations of your Primary Care Physician.
- Communicate regularly with your Primary Care Physician making sure that we receive and provide information to coordinate your care.
- Consider all your needs when we work with you to develop your treatment plans and health goals.
- Have open and honest discussions with you regarding your health and plans for managing your care.
- Provide you with information to help you learn how to self-manage your condition, and assist you with establishing goals for the chronic condition we are assisting you with.
- Work with you to create a plan for any other urgent health care need that may arise related to your chronic condition.
- Be available to you by phone and in the office to answer your questions and concerns as they arise.

This means you should make every effort to:

- Make and keep all appointments recommended by our office. If you must cancel an appointment, make every attempt to reschedule it as soon as possible.
- Follow through with recommended testing and contact the office if you cannot get these tests completed.
- Participate and commit to the treatment plan and health care goals developed by you and your physician or other health professional.
- Be sure you understand the treatment plan. If you do not understand, ask questions until you feel comfortable with the agreed upon treatment plan.
- Tell us immediately if you are not able to follow the treatment plan for any reason so we can assist you in adjusting the plan so you get the best results.
- Follow up with your Primary Care Physician for your overall healthcare needs.

As part of comprehensive quality care and to support population management healthcare information is shared among care partners as necessary.



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Association**



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INSTITUTE OF NEUROMUSCULAR MEDICINE

Cancellation Policy

A specific time has been reserved especially for you. A broken appointment is a loss and inconvenience to everyone.

As a courtesy, we attempt to confirm appointments the day before. However, we do not assume responsibility for the appointment time.

If you need to change your appointment, we require at least a 24-hour notice. We reserve the right to charge for appointments broken or cancelled without 24-hour advanced notice. Our charges are as follows:

Physician Appointments:

\$90.00 fee for a 30-minute appointment

Massage, Yoga and Physical Therapy:

\$50.00 fee for 30-minute appointment

\$80.00 fee for 60-minute appointment

We appreciate your understanding and cooperation in this matter.



Co-Payment and Out-of-Pocket Costs

Out of pocket and co-payments are contractual obligations with your insurance company. You are required to pay these services at the time of each visit. Out of pocket costs may include, but are not limited to:

- Co-pays on office visits
- Deductibles/co-payments
- Non-covered services
- Forms that need to be completed by your physician

If you cannot make your required out of pocket costs or co-payments, we reserve the option to:

- Reschedule your appointment
- Charge a \$2.50 administrative fee in addition to your co-pay for that date of service

To our cash patients:

We understand that medical costs can be overwhelming. Here at Eastpointe Family Physicians we will do what we can to keep your medical costs down. Unfortunately, we cannot have one set fee for your visit. The provider you see at the time of service determines this according to the level of service provided. We cannot quote you what your charges will be before you see the doctor. Payment is expected in full at the time of service. If payment is received at the time of the visit, your services will be discounted

You are being given a “Verification and Authorization” signature page to sign acknowledging receipt and understanding of this policy. Please feel free to take a copy of this policy for your records. If you have any questions, please ask to speak to Candi.

Patient Information

Patient Name: _____ Soc.Sec.No: _____

Address: _____
Street City State Zip Code

Phone: () _____ () _____ () _____
Home Business Cell

Date of Birth: _____ Email Address: _____

Employer: _____ Occupation: _____ () _____
Pharmacy: Name & Location or ph#

How did you hear about our office: _____

Insurance Card Holder Information:

Name of Policy Holder: _____ Relationship: _____ Date of Birth: _____

Address of policy holder: _____ Phone: _____

Emergency Contact Information:

Emergency Contact: _____ Relationship: _____

Emergency Contact Numbers: () _____ () _____
Home Cell

Please answer the following:

Can we leave Private Health Information (such as, but not limited to: normal test results, medication changes, etc) on your answering machine or by email? Yes No If no, please specify below:

No one other than myself Spouse (Name) _____ Other (Name) _____

I authorize this office to call and confirm scheduled appointments one to two days in advance and to leave a message on home voicemail / recorder or with another family member: Yes No

Do you have an Advanced Directives and Power of Attorney for Health Care? _____ If not, would you like us to provide you with this information? Yes No

Please sign:

Patient or Guardian Signature Relationship Date

We will need copies of your insurance card and drivers license



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Institute of Neuromuscular Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Institute of Neuromuscular Medicine describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Institute of Neuromuscular Medicine reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Institute of Neuromuscular Medicine.

With this consent, Institute of Neuromuscular Medicine may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Institute of Neuromuscular Medicine may mail to my home or other alternative location, any items that assist the practice of carrying out TPO, such as appointment reminder cards and patient statements so long as they are marked "Personal and Confidential."

With this consent, Institute of Neuromuscular Medicine may email to my home or other alternative location, any items that assist the practice of carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request how that Institute of Neuromuscular Medicine restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Institute of Neuromuscular Medicine to use and disclose PHI to carryout TPO. In the course of providing care, our providers will share patient information with other providers who are involved in the patients care as appropriate.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or revoke it later, Institute of Neuromuscular Medicine may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Legal Guardian (if applicable)

Verifications and Acknowledgments

Policies and Procedures:

I acknowledge that I read and/or received a copy of the Institute of Neuromuscular Medicine, P.L.C. Patient Notice of Privacy Practices effective September 23, 2013:

Signature: _____ Date: ____ / ____ / ____

Out-of-Pocket and Co-Payment Policy:

I have been presented with a copy of the out of pocket and copayment policies and understand my responsibilities:

Signature: _____ Date: ____ / ____ / ____

Cancellation Policy:

I have been presented with a copy of the cancellation policy and understand my responsibilities:

Signature: _____ Date: ____ / ____ / ____

Privacy Policy:

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State law, and outlining my rights regarding my health information:

Signature: _____ Date: ____ / ____ / ____

Authorization to Release Information and Assignment of Benefits:

I authorize the release of any medical information necessary to process my claim. I permit a copy of this authorization to be used in place of the original:

Signature: _____ Date: ____ / ____ / ____

I hereby authorize Institute of Neuromuscular Medicine to apply for benefits on my behalf for covered services rendered by Dr. Shah or his associates. I request that payment from my insurance company be made directly to Institute of Neuromuscular Medicine. I permit a copy of this authorization to be used in place of the original:

Signature: _____ Date: ____ / ____ / ____

Today's Date: _____

Patient Name: _____

DOB: _____

HISTORY OF CHIEF COMPLAINT

Why would you like to be seen? _____

Symptoms came on: Suddenly Gradually Describe: _____

How long have you experienced these symptoms? _____

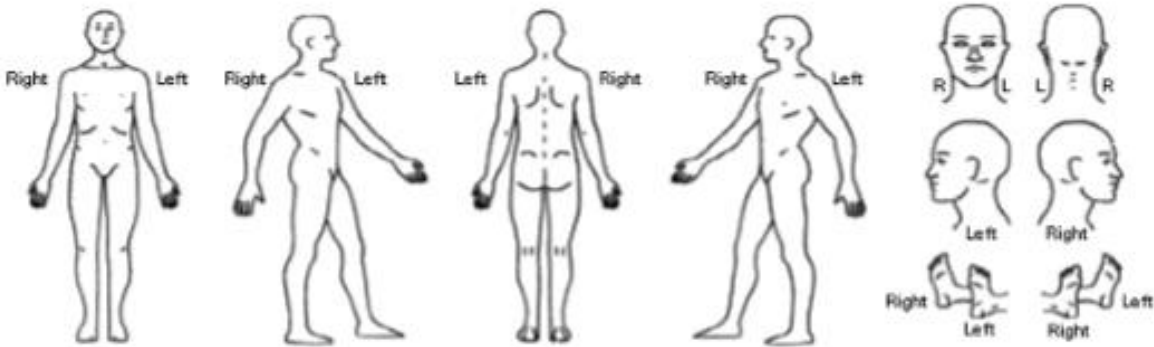
How did the episode of pain occur? Work-related injury Recreational accident
 Vehicle accident No known cause
 Other _____

If your pain is the result of an injury, please describe the incident in detail. Date of accident/injury: _____

Mark the areas on this diagram where you currently experience pain using the codes indicated below. Include all affected areas. **Lightly** shade areas of pain. If pain is intense in a particular area, **darkly** shade those areas.

KEY

Use letters below to indicate type and location of discomfort			
A = Ache	B = Burning	S = Sharp/Stabbing	O = Other
N = Numbness	P = Pins & Needles	T = Tightness/Stiffness	



How would you describe your overall severity of pain? Mild nuisance Severe. It is ruining the quality of my life.
 Mild to moderate, but I can live with it None, I have no pain.
 Moderate. I am having difficulty dealing with it.

How frequently does your pain occur? Constantly Present Comes and goes

Does the pain vary in intensity? If so, what seems to make it better or worse?

	Heat	Ice	Rest	Certain position	Movement/stretching
Better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR TREATMENTS

Treatment	Result	Treatment	Result
<input type="checkbox"/> Spinal injections	_____	<input type="checkbox"/> Chiropractic	_____
<input type="checkbox"/> Trigger Point injections	_____	<input type="checkbox"/> Osteopathic	_____
<input type="checkbox"/> Steroid injections	_____	<input type="checkbox"/> Surgery	_____
<input type="checkbox"/> Prescriptions	_____	<input type="checkbox"/> Acupuncture	_____
<input type="checkbox"/> Bracing	_____	<input type="checkbox"/> TENS unit	_____
<input type="checkbox"/> Traction	_____	<input type="checkbox"/> Corrective Exercises	_____
<input type="checkbox"/> Massage	_____	(trainer or yoga instructor)	_____
Other: _____	_____	Other: _____	_____

TESTS DONE

***** Please bring copy of any reports and discs/films to your first appointment *****

Test	Date	Result
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST YOUR OTHER HEALTHCARE PROVIDERS

Provider	Specialty	Problem being treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL PRIOR SURGERIES

Type of surgery	Body location	Month/Year	Surgeon/Facility
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CANCER HISTORY

Location: _____	When: _____	Additional Information: _____
Treatment: _____	Status: _____	_____

SYSTEM REVIEW

Current and Past Medical History	Check the following symptoms that you are CURRENTLY experiencing
<input type="checkbox"/> Chicken pox <input type="checkbox"/> Hepatitis: Type _____ <input type="checkbox"/> Other: _____	<p style="text-align: center;">General/Constitutional</p> <input type="checkbox"/> Weakness <input type="checkbox"/> Chills <input type="checkbox"/> Change in weight/appetite <input type="checkbox"/> Night sweats <input type="checkbox"/> Fevers <input type="checkbox"/> Change in sleeping habits <input type="checkbox"/> Fatigue
<input type="checkbox"/> HIV <input type="checkbox"/> Herpes <input type="checkbox"/> Other: _____	<p style="text-align: center;">Mood/Sleep</p> <input type="checkbox"/> Falling asleep <input type="checkbox"/> Poor memory <input type="checkbox"/> Anxiety <input type="checkbox"/> Staying asleep <input type="checkbox"/> Indecisiveness <input type="checkbox"/> Moodiness <input type="checkbox"/> Early awaking <input type="checkbox"/> Low self-esteem <input type="checkbox"/> Not awaking rested <input type="checkbox"/> Loss of interest <input type="checkbox"/> Sleeping too much <input type="checkbox"/> Sad mood <input type="checkbox"/> Witnessed apnea <input type="checkbox"/> Poor concentration
<input type="checkbox"/> Depression <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Other: _____ <input type="checkbox"/> ADD/ADHD	<p style="text-align: center;">Cardiovascular</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Trouble breathing at night <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Trouble climbing stairs <input type="checkbox"/> Easy fatigue <input type="checkbox"/> Blood clots/phlebitis <input type="checkbox"/> Palpitations/heart pounding
<input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Addiction/Abuse _____	<p style="text-align: center;">Nervous System</p> <input type="checkbox"/> Headache <input type="checkbox"/> Double vision <input type="checkbox"/> Tremor/hand shaking <input type="checkbox"/> Dizziness <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Loss of Coordination <input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> CHF <input type="checkbox"/> Blocked Artery <input type="checkbox"/> Blood Clots <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other: _____ <input type="checkbox"/> Rheumatic Fever	<p style="text-align: center;">Gastrointestinal</p> <input type="checkbox"/> Stomach/abdominal pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Indigestion/heartburn <input type="checkbox"/> Vomiting/nausea <input type="checkbox"/> Black, tarry stools <input type="checkbox"/> Diarrhea/constipation <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Blood in stools <input type="checkbox"/> Loss of control of bowels
<input type="checkbox"/> Migraines <input type="checkbox"/> Other Headaches <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Parkinson's	<p style="text-align: center;">Respiratory</p> <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath with minimal exertion <input type="checkbox"/> Frequent bronchitis <input type="checkbox"/> Frequent or chronic cough
<input type="checkbox"/> Concussion/Closed Head injury/ Traumatic Brain Injury <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____	<p style="text-align: center;">Genitourinary</p> <input type="checkbox"/> Pain w/ urination <input type="checkbox"/> Weak stream <input type="checkbox"/> Urgency <input type="checkbox"/> Frequent infections <input type="checkbox"/> Leaking urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Loss of bladder control <input type="checkbox"/> Difficulty starting stream <input type="checkbox"/> Excessive nighttime urination
<input type="checkbox"/> Stomach/Duodenal Ulcer <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Other: _____	<p style="text-align: center;">Endocrine/Heme/Lymph/Immune</p> <input type="checkbox"/> Excessively hot <input type="checkbox"/> Always hungry <input type="checkbox"/> Easy bruising <input type="checkbox"/> Excessively cold <input type="checkbox"/> Swollen glands <input type="checkbox"/> Swelling <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Pain or tightness in legs w/ walking <input type="checkbox"/> Discoloration of hands or feet
<input type="checkbox"/> Asthma <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other: _____	<p style="text-align: center;">Eyes, Ears, Nose, Throat</p> <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Double vision <input type="checkbox"/> Blurring or spots <input type="checkbox"/> Loss of/decreased hearing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Eye pain <input type="checkbox"/> Taste or smell changes <input type="checkbox"/> Neck swelling <input type="checkbox"/> Double vision <input type="checkbox"/> Excessive snoring <input type="checkbox"/> Frequent sore throats
<input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Lupus <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Psoriasis <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Eczema <input type="checkbox"/> Other: _____	<p style="text-align: center;">Medical Allergies</p> <input type="checkbox"/> Allergies (Seasonal) <input type="checkbox"/> Hearing Loss <input type="checkbox"/> TMJ Problems <input type="checkbox"/> Other: _____ Medical Allergies: _____ Reaction: _____

SOCIAL AND PERSONAL HISTORY

Currently live: Alone With family With significant other With friends

Last grade/degree completed in school: _____

Occupation: _____

Are there any health risks associated with your job, home environment, or activities? Yes No

If yes, please explain: _____

Diet and Nutrition

Do you exercise regularly? Yes No How often? _____ Type: _____

Approximate # of glasses of water consumed per day _____

Do you mostly: Cook at home Eat out Eat prepared or prepackaged foods

Do you eat a lot of: Vegetables Fruits Sugar Fats Animal products

Coffee or tea? Regular Decaffeinated None Number of cups/day: _____

Habits

Do you currently smoke? Yes No If yes, how much: _____ How many years: _____

Are you a former smoker? Yes No

Do you chew tobacco? Yes No

Do you drink alcohol? Yes No Amount: _____ oz # _____ of drinks per week/month/year

Do you currently use drugs? Yes No Type: _____ Frequency: _____

Have you ever used drugs? Yes No Type: _____ Frequency: _____

Family Health History

Have any family relatives (mother, father, brother, sister, grandfather, grandmother, aunt, uncle, cousin, nephew, niece, son, daughter) suffered from any of the following? Please list the people relative to their relationship to you:

<u>Condition</u>	<u>Relationship to you</u>	<u>Condition</u>	<u>Relationship to you</u>
Cancer	_____	Nerve/muscle diseases	_____
Heart trouble	_____	Seizures (fits, epilepsy)	_____
Stroke	_____	Anemia (low blood)	_____
Asthma or hayfever	_____	Bleeding problems	_____
Diabetes (sugar)	_____	Rheumatic fever	_____
Gout	_____	Alcoholism	_____
Kidney disease	_____	Mental illness	_____
Arthritis	_____	Physical Deformity	_____
Other: _____	_____	Other: _____	_____

