Internal Medicine and Pediatrics of Bloomfield, PC
Steve Kallabat, MD
Azrael Paredes, MD
Jamie Chioini-Baines, DO

Registration Information

Last Name_____ First Name_____ MI____

Date of Birth____/____/____ Age_____ Gender: **Male Female** Social Security Number ____-____-____

Address_____City_____ State_____ Zip_____

Cell Phone (_____)_____ Home Phone (_____)_____

Work Phone (_____)_____ext._____ Email _____
Please circle which number is best for us to reach you: **Cell Home Work**

Emergency Contact:_____ Relationship_____ Phone _____
Can we discuss your medical/financial information with anyone? **Yes or No**
If so, who?_____ Relationship_____ Phone _____

Local Pharmacy Name_____ Address _____Phone_____

Mail Order Pharmacy_____Address_____Phone_____

Please circle which race best represents you: **White /African-American/Asian/Other:**_____
Please circle which ethnicity best represents you: **Hispanic/Latino Other:**_____
What Language is spoken in home: _____
Marital Status: **Single Married Divorced Widowed Separated**

Insurance Information

Primary Insurance:_____

Subscriber Name:_____SSN_____DOB_____

Patient relationship to subscriber: **Self Spouse Parent Child Other**_____

Secondary Insurance:_____

Primary Insurance:_____

Subscriber Name:_____SSN_____DOB_____
Patient relationship to subscriber: **Self Spouse Parent Child Other**_____

Referral Source – How did you learn about our practice?
Newspaper Phonebook Brochure Radio Other_____

Physician Referral_____
Name
Friend or Family Member_____
Name

Authorization for release of medical records and assignment of benefits

I hereby authorize the release of medical information necessary to process insurance claim forms. In addition, I request claims be submitted on my behalf and payment for services rendered be directly made to Internal Medicine and Pediatrics of Bloomfield, PC. I understand that I am financially responsible for amounts applied to insurance policy deductibles and co-payments not covered by my insurance company.

Patient Signature/Guardian Signature_____ Date_____

Internal Medicine and Pediatrics of Bloomfield, PC

This is an agreement between Internal Medicine and Pediatrics of Bloomfield, PC, located at 1109 W. Long Lake Road, Bloomfield Hills, MI 48302 and _____ located at _____.
Name Address

In this agreement the words "you", "your", and "yours" means the patient. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refers to Internal Medicine and Pediatrics of Bloomfield, PC.

By executing this agreement, you agree to pay for all services that are received as well as the following and subject to all of the terms and conditions set forth herein.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charges, if any, and any payments or credits applied to your account during the month.

Payment Options: You may choose pt pay by cash or credit card on the day that treatment is rendered.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service, in full.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible at the time service is rendered. It is the insurance company that makes the final determinations of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-Contracted Insurance: Your insurance policy is a contract between you and your insurance company. If we are NOT a party to this contract, we will bill you primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Statement Fee: A billing fee of $5 will be imposed on each statement that is sent to Patient due to Patient's non-payment on the date of service. After the fourth consecutive statement with no Patient response, we will no longer be able to see you in our office, and you may be sent to collections.

Address:
1109 W. Long Lake Rd.
Bloomfield Hills, MI 48302

Contact:
Phone: 248-723-2400
Fax: 248-723-5785

Internal Medicine and Pediatrics of Bloomfield, PC

Co-payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot waive these fees.

Deductibles: Patients who have a high deductible insurance policy will be required to pay a portion of the office visit at the time of service. You will be responsible for the difference of the fee collected on the day of service and the amount billed to your insurance company.

Payment: I assign and authorize payment from my insurance company directly to Internal Medicine and Pediatrics of Bloomfield, for any and all services rendered. I agree to pay, at the time of service or on an interim basis (agreed upon by Internal Medicine and Pediatrics), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay Internal Medicine and Pediatrics of Bloomfield, PC all charges for services rendered irrespective of any disputes or disagreements between me and my insurance company.

Returned Checks: There is a $35 fee for any checks returned by the bank.

Missed Appointments: Patients with two missed appointments may be asked to transfer their records to another doctor.

No Shows: Patients who do not keep their appointment will be charged a fee of $25. If this fee is not paid before the next visit, patient will not be seen until this is taken care of. Patients who do not cancel 24 hours prior and no show for their physical appointment will be charged $50 and will be applied to their balance.

Past Due Accounts: If your account becomes past due, we will take any legal steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. There will also be a 30% additional cost added to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all actual attorney fees which we incur plus all court costs and other charges. In case of suit, you agree that such venue shall be the courts in Oakland County, Michigan.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you have received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent.

Transferring of Records: You will need to make a written request and pay a $25 fee if you want to pick up a copy of your records. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Master Medical: If you have master medical, you will be required to pay all of your office visit fees at the time of service. We will bill BCBS as a courtesy in order for you to be reimbursed by the carrier.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein and the agreement will be in full force and effect.

Patient Name: _____ Responsible Party: _____ (if not the patient)

Patient Signature: _____ Date: _____

Internal Medicine and Pediatrics of Bloomfield, PC

GENERAL CONSENT TO TREATMENT

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

1. **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include diagnostic, radiology and laboratory procedures, blood transfusions, anesthesia, therapeutic procedures, drugs, and medical, nursing and hospital care.
2. **Release of Information**: I as a patient of Internal Medicine and Pediatrics of Bloomfield am aware and clearly understand that in the course of providing care, providers will share patient information with other providers who are involved in the patient's care, as appropriate. I authorize Internal Medicine and Pediatrics of Bloomfield to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records, and social work records, if any. See Notice of Privacy Practices for further information.
3. **Human Immunodeficiency Virus (HIV) and Hepatitis B (HBV) Testing**: I understand and agree that, in accordance with State Law, and HIV or HPV test may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of my test will be treated confidentially.
4. **Testing and Disposal of Specimens and Tissues**: I authorize William Beaumont Hospital to retain, preserve, or use for research, scientific or teaching purposes or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.
5. **No Guarantees**: I am aware that the practice of medicine and surgery are not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

_____ _____

Date *Signature of patient/parent (if patient is a minor)/legal guardian/patient advocate/closest relative (if patient is unable to consent)*

_____ _____

Signature of Witness *Please indicate relationship*

History Form

First Name:_____ **Last Name:**_____ **Date of Birth:**_____

Past Medical History: **(check all that apply)**

[ ] MENOPAUSE
[ ] HIGH CHOLESTEROL
[ ] HEART ATTACK
[ ] STROKE
[ ] PEPTIC ULCERS
[ ] ASTHMA
[ ] HYPOTHYROIDISM
[ ] ARTHIRITIS
[ ] GLAUCOMA
[ ] HEART ARRYTHMIA
[ ] KIDNEY STONES
[ ] PNEUMONIA
[ ] SLEEP APNEA
[ ] KIDNEY FAILURE
[ ] ANEMIA
[ ] SEASONAL ALLERGIES
[ ] CHRONIC LOW BACK PAIN
[ ] EMPHYSEMA/CHRONIC BRONCHITIS
[ ] FIBROID UTERUS
[ ] HYPERTENSION (HIGH BLOOD PRESSURE)
[ ] DIABETES: CONTROLLED BY ( ) DIET ( ) MEDICATION ( ) INSULIN
[ ] MIGRAINES/CHRONIC HEADACHES
[ ] ACID REFLUX
[ ] CATARACTS
[ ] CANCER-TYPE_____
[ ] OSTEPOROSIS
[ ] OBESITY
[ ] FREQUENT URINARY TRACT INFECTIONS
[ ] CONGESTIVE HEART FAILURE
[ ] TRANSFUSIONS OF BLOOD PRODUCTS
[ ] OTHERS:_____

PAST SURGERIES/PAST PROCEDURES

[ ] HERNIA REPAIR DATE: SIDE: LEFT RIGHT BOTH
[ ] TONSILS DATE:
[ ] ADENOIDS DATE:
[ ] PLASTIC SURGERY DATE: TYPE OF SURGERY:
[ ] PACEMAKER DATE:
[ ] HEART BYPASS DATE: # OF VESSELS:
[ ] ORTHOPEDIC/JOINT SURGERY DATE: TYPE OF SURGERY
[ ] HYSTERECTOMY ( ) AND LEFT OVARY ( ) AND RIGHT OVARY ( ) AND BOTH OVARIES
[ ] LAPAROSCOPY DATE:
[ ] PROSTATE RESECTION/BIOPSY DATE:
[ ] BREAST BIOPSY SIDE: DATE:
[ ] HEART CATHETERIZATION/ANGIOPLASTY DATE:

DIAGNOSTIC TESTS

[ ] COLONOSCOPY/SIGMOIDOSCOPY DATE:
[ ] STRESS TEST DATE:
[ ] ECHOCARDIOGRAM (HEART ULTRASOUND) DATE:
[ ] CAROTID ULTRASOUND DATE:
[ ] BONE MINERAL DENSITY DATE:
[ ] MAMMOGRAM DATE:
[ ] EYE EXAM DATE:
[ ] OTHERS:_____

MEDICATIONS: **(LIST NAME, DOSE AND FREQUENCY)**

EXAMPLE: MOTRIN 600MG TWICE A DAY

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

MEDICATION ALLERGIES **(LIST THE MEDICATION AND THE TYPE OF REACTION)**

[ ] ASPIRIN [ ] SULFA [ ] PENICILLIN
[ ] CODEINE [ ] ERYTHROMYCINS [ ] ANTIHISTAMINES
[ ] OTHERS:_____

PATIENTS NAME:_____

SOCIAL HISTORY:

[ ] MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED

[ ] CIGARETTE USE

{ } **Yes** How many packs do you smoke per day?_____ How many years have you smoked?_____

{ } **No**

{ } **Previous smoker** How many years did you smoke? ____ When did you quit? ____

[ ] CIGAR USE

[ ] PIPE USE

[ ] ALCOHOL USE _____DRINKS/DAY

[ ] MARIJUANA USE _____LAST USE

[ ] COCAINE USE _____LAST USE

[ ] INTRAVENOUS DRUG USE _____LAST USE

[ ] CURRENTLY EMPLOYED OUTSIDE OF THE HOME

[ ] PETS [ ] DOGS [ ] CATS [ ] BIRDS [ ] EXOTIC ANIMALS

SEXUAL PREFERENCES [ ] MEN [ ] WOMEN [ ] BOTH

PLACE OF BIRTH:_____

HOUSEHOLD MEMBERS:_____

_____

HEALTH MAINTENANCE:

[ ] PNEUMONIA VACCINE ____YEARS GIVEN

[ ] FLU VACCINE

[ ] PREVIOUS CHICKEN POX

[ ] HEPATITIS VACCINE SERIES

[ ] GARDASIL VACCINE

[ ] TETANUS VACCINE

[ ] YEARLY PROSTATE EXAM

[ ] YEARLY GYNECOLOGIC EXAM

[ ] YEARLY STOOL EXAM

[ ] YEARLY BREAST EXAM

FAMILY HISTORY:

LIST ALL MAJOR MEDCAL ILLNESSES WITH EACH RELATIVE

MOTHER	[ ] HEALTHY	OTHER_____
FATHER	[ ] HEALTHY	OTHER_____
SISTER #1	[ ] HEALTHY	OTHER_____
SISTER #2	[ ] HEALTHY	OTHER_____
SISTER #3	[ ] HEALTHY	OTHER_____
SISTER #4	[ ] HEALTHY	OTHER_____
BROTHER #1	[ ] HEALTHY	OTHER_____
BROTHER #2	[ ] HEALTHY	OTHER_____
BROTHER #3	[ ] HEALTHY	OTHER_____
BROTHER #4	[ ] HEALTHY	OTHER_____
MATERNAL GRANDMOTHER	[ ] HEALTHY	OTHER_____
PATERNAL GRANDMOTHER	[ ] HEALTHY	OTHER_____
MATERNAL GRANDFATHER	[ ] HEALTHY	OTHER_____
PATERNAL GRANDFATHER	[ ] HEALTHY	OTHER_____
MATERNAL AUNTS	[ ] HEALTHY	OTHER_____
MATERNAL UNCLES	[ ] HEALTHY	OTHER_____
PATERNAL AUNTS	[ ] HEALTHY	OTHER_____
PATERNAL UNCLES	[ ] HEALTHY	OTHER_____

PATIENT SIGNATURE:_____DATE:_____

Internal Medicine and Pediatrics of Bloomfield, PC

Review of Body System (Patient to fill out)

HEART (CARDIOVASCULAR SYSTEM)

☐	chest pain	☐	cramping in legs while walking
☐	palpitations	☐	awakening in the night with sudden difficulty breathing
☐	dizziness/lightheaded	☐	loss of consciousness
☐	leg swelling	☐	difficulty breathing while laying down

LUNGS (PULMONARY SYSTEM)

☐	cough	☐	cough with blood	☐	wheezing
☐	difficulty breathing	☐	excess sputum production		
☐	chronic cough (longer than one month)	☐	difficulty breathing with exertion		

BOWELS (GASTROINTESTINAL SYSTEM)

☐	abdominal pain	☐	bright red or maroon stools	☐	nausea
☐	abdominal mass	☐	difficulty swallowing	☐	heartburn
☐	change in bowel health	☐	vomit with blood	☐	vomiting
☐	constipation	☐	dark black stools	☐	diarrhea

NERVOUS (NEUROLOGICAL SYSTEM)

☐	decreased memory	☐	headaches (other)	☐	loss of coordination
☐	difficulty speaking	☐	headaches (migraines)	☐	visual changes
☐	difficulty walking	☐	seizures	☐	weakness
☐	numbness in limbs	☐	vertigo (spinning)	☐	tremor

MUSCULOSKELETAL (MUSCLE & BONE)SYSTEM

☐	joint redness	☐	morning stiffness	☐	muscle ache
☐	joint deformity	☐	joint pain	☐	muscle fatigue/weakness
☐	chronic/long term back pain	☐	joint swelling	☐	chronic/long term neck pain

URINARY TRACT SYSTEM

☐	urinating frequently	☐	urinating blood	☐	painful urination
☐	awakening frequently to urinate	☐	urinary leakage	☐	weak urine stream

EAR, NOSE, AND THROAT

☐	runny nose	☐	red eyes	☐	sore throats
☐	nose bleeds	☐	itchy/watery eyes	☐	bad breath
☐	nasal congestion	☐	oral lesions	☐	enlarged tonsils
☐	snoring	☐	excessive sneezing	☐	ear aches
☐	hearing loss/muffled	☐	ringing in the ears	☐	vertigo

SKIN (DERMATOLOGY)

☐	rash	☐	dark moles	☐	growing skin lesions
☐	new skin lesion	☐	easy bruising	☐	slow healing cuts
☐	keloid/scar formation	☐	loss of pigment	☐	loss of hair

GYNECOLOGIC/UROLOGIC

☐	menopausal	☐	change in menstruation	☐	excessive bleeding
☐	painful menstruation	☐	cyclical mood changes	☐	breast tenderness
☐	breast mass/lump	☐	nipple discharge	☐	vaginal dryness/irritation
☐	vaginal discharge	☐	penile discharge	☐	penile lesion
☐	1st day of last menstrual period___/___/___	☐	testicular pain	☐	testicular mass

PSYCHIATRY

☐	depression	☐	anxiety state	☐	manic episode
☐	personality disorder	☐	obsessive/compulsive	☐	hallucinations
☐	post-traumatic syndrome	☐	alcohol/substance addiction		

ENDOCRINE/GLANDULAR SYSTEM

☐	weight gain	☐	weight loss	☐	increased thirst
☐	increased appetite	☐	tremors/shaky	☐	stretch marks
☐	fatigue	☐	increased perspiration	☐	excessive hair growth

Patient signature:_____ **Date:**_____

How To Get Lab and Imaging Test Results

1. Signing for the patient portal is easy.
An email will be sent to your email address with a link.

(If you deleted/lost the email, please ask the front desk to resend it.)

Sign up for patient portal **ONLY** through the email we send you titled **"Follow My Health."**
You must sign up by **clicking on this email from a computer (not a tablet or smartphone.)**
Do not register from our website.
Follow the steps to register from the patient portal. You can create an account with the FMH secure log in, or login through an existing account like Google or Yahoo. With an existing account it may be easier to remember your password.
Signing up with FMH secure login: Password should be at least 8 characters in length, and include at least one numeric and one special character, such as !@#$%^&*-(
Write down your password in a secure spot.
The first time you log into the app, you will be prompted to enter your 4 digit password to verify that it is you. It will be 1234.

2. Download app for your phone for easy access to the patient portal.

In your app store search: **"Follow My Health"** and download and open and login.
The app name appears exactly as FollowMyHealth® Mobile

3. Once registered, check your labs online: https://www.followmyhealth.com/

Or access from our website: www.medpedsdoc.com – click the patient portal tab on the left.

4. Lab results protocol:

All lab results will be released to the Patient Portal once reviewed by the physician, typically within 1-3 business days.If not on the patient portal, labs are released via mail 7 days after the blood draw. Only urgent abnormal labs are resulted by telephone.
We strongly encourage all patients to register for the patient portal.

5. The patient portal is not monitored as an inbox.

Do not reply to messages or send questions through this way. The patient portal is used for outgoing messages only, although it does allow them to go through. For medical questions please call our office (248) 723-2400, or for medical emergencies call 911 or go to the ER.

Thank you for taking responsibility for your health.
The healthiest people are active and knowledgeable about their medical care!

I understand and agree to the above policies: _____Date: _____

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Bloomfield Hills, MI 48302
Ph: 248.723.2400 Fax: 248.723.5785

Annual Adult Wellness Exam

The purpose of an adult wellness exam is to address therapeutic lifestyle changes to optimize overall health. Annual wellness exams may also be called a physical, yearly check-up, or preventive visit. This discussion includes:

- BMI (Body Mass index, height, and weight)
- Nutrition/ diet
- Nutrients/ Vitamins
- Importance of Exercise
- Blood Pressure
- Review of Female Screening Guidelines: (pap smear for cervical cancer, STD screening, self breast exams, mammograms screening for breast cancer, DEXA screening for osteoporosis)
- Review of Male screening Guidelines: (STD screening, testicular cancer screening, prostate cancer screening)
- Guidelines for Screening for colon cancer by colonoscopy
- Immunization review: Tdap, Hepatitis A and B, Shingles, Pneumonia, HPV,
- Fasting Labs: CBC, BMP, Lipid Panel, TSH
- Screening for cardiac disease: EKG
- Screening for pulmonary disease: PFT
- Other screenings:
    - One time Hepatitis C screening for adults 65 and older
    - Smokers: Guidelines for Low Dose CT screening for Lung Cancer
    - High Risk Cardiac Disease: Cardiac CT for Calcium Scoring
- Medication List Update
- Patient Portal sign up reminder for lab result explanations

An Adult Wellness Exam does not include discussion of new problems or detailed review of chronic conditions. Insurance does not pay for this benefit at the time of your yearly physical. We ask that the discussion be focussed on the above wellness topics. We'd be happy to see you for a follow up appointment to discuss any new or existing problems you may have.

I agree with the above policy and if I have other health issues, I will make a separate appointment to discuss these issues.

Signature: _____ **Date:**_____