24400 GREATER MACK AVENUE
ST. CLAIR SHORES, MI 48080
PHONE: (586)778-1881
FAX: (586)778-0667

NEW PATIENT PACKET

Welcome to Waypointe Internal Medicine, P.C. We are pleased that you have chosen us to be your primary care provider. Enclosed is our New Patient Packet for your review and completion.

We ask that you **thoroughly review and complete the enclosed paperwork**. **It is very important that all the enclosed forms are completed IN FULL**. Within 4-5 business days of the completed packet being returned to our office, a staff member will call you to schedule a new patient appointment. Failure to return the enclosed forms or returning incomplete forms will result in a delay of scheduling your appointment. Please be advised that all incomplete forms will be returned to you for completion.

If you are transferring your care from another provider, you may contact that provider and request that your records be transferred to us, however, this is not a requirement for your initial appointment. If you do choose to do this, our staff will provide you a medical record release form upon your request. Once filled out, our staff will fax it to your previous provider.

As a new patient, we ask that you arrive 20 minutes prior to your scheduled appointment time. **You must bring at least one form of identification (driver's license, State ID), your insurance card(s), and all current medications in the original containers**. All insurance co-pays and deductibles are due and must be paid in full for all services performed at the time of the visit.

Thank you for choosing Waypointe Internal Medicine, P.C. We look forward to serving your healthcare needs.

Waypointe
Internal Medicine, PC

NEW PATIENT INFORMATION

Provider you will be seeing:_____

Patient's Full Name:_____
(First) (Middle) (Last)

Social Security #:_____ Gender: M F Date of Birth:_____

Address:_____
(Street) (City) (State) (Zip)

Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____

Work Phone: ( )_____-_____ ext. _____ E- mail:_____

Race (circle): White Black/ African American Asian American Indian Other

Ethnicity (circle): Hispanic or Latino Non- Hispanic or Latino Other

Preferred Language (circle): English Spanish Arabic Italian Other

Patient's Employer Name:_____

Position: _____

How did you hear about us?_____

Emergency Contact Name:_____Relation:_____

Phone: ( )_____-_____

Address:_____
(Street) (City) (State) (Zip)

Is this person allowed to be informed of any information regarding your medical condition?
Please Circle: Yes No

Patient's Preferred Pharmacy:_____Phone: ( )_____-_____

Address:_____
(Street) (City) (State) (Zip)

Patient Insurance Information

If your insurance plan is an HMO, you MUST call them and inform them of your new PCP BEFORE an appointment is scheduled.

Primary Insurance:_____

Member ID:_____ Group Number:_____

Policyholder Name:_____

Relation to Policyholder (if not self):_____

Secondary Insurance (if applicable):_____

Member ID:_____ Group Number:_____

Policyholder Name:_____

Relation to Policyholder (if not self):_____

Tertiary Insurance (if applicable):_____

Member ID:_____ Group Number:_____

Policyholder Name:_____

Relation to Policyholder (if not self):_____

NEW PATIENT MEDICAL INFORMATION

PAST MEDICAL HISTORY: Please list all medical conditions you currently have or have had in the past that we should be aware of.

_____

_____

_____

SCREENING HISTORY: Please write the **last date AND location** you had the following screenings, if applicable.

Mammogram:_____

Colon Cancer Screening:_____

Pap Smear:_____

PSA:_____

Eye Exam:_____

Bloodwork:_____

ALLERGIES: List allergen and type of reaction. Write N/A if none.

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Surgical History: Please list any surgeries you have had in the past that we should be aware of. If applicable, please make sure you write left or right corresponding to the side you had surgery on.

_____

_____

_____

Current Medications: List name and dose of each medication you are currently taking.

Medication:_____Strength:_____Times per Day:_____

Medication:_____Strength:_____Times per Day:_____

Medication:_____Strength:_____Times per Day:_____

Medication:_____Strength:_____Times per Day:_____

Medication:_____Strength:_____Times per Day:_____

Medication:_____Strength:_____Times per Day:_____

Family History: Please fill out this section to the best of your knowledge. If family member is deceased, please mark the age spot with the letter "D".

Mother: Age_____ Medical History:_____

Father: Age_____ Medical History:_____

Sibling(s) Age_____ Medical History:_____

Paternal Grandmother: Age_____ Medical History:_____

Paternal Grandfather: Age_____ Medical History:_____

Maternal Grandmother: Age_____ Medical History:_____

Maternal Grandfather: Age_____ Medical History:_____

Paternal Aunt: Age_____ Medical History:_____

Paternal Uncle: Age_____ Medical History:_____

Maternal Aunt: Age_____ Medical History:_____

Maternal Uncle: Age_____ Medical History:_____

Children: Age_____ Medical History:_____

Other: Relation_____ Age_____ Medical History:_____

Social History

SUBSTANCE ABUSE

Cigarette Smoking: Yes___ No ___ If yes, how many packs per day?_____

Past Smoking History: Yes____ No____ If yes, what year did you quit?_____

Chewing Tobacco: Yes_____ No_____

Alcohol Use: Yes_____ No_____
If yes, how many alcoholic drinks do you consume per week?_____

Recreational Drug Use: Yes_____ No_____ If yes, what type of drug?_____

LIVING SITUATION

Living With (circle): Alone Spouse Parents Partner Children Other_____

Are there pets at home? Yes_____ No_____ If yes, what type?_____

WORK/SCHOOL

Occupation:_____ Full Time_____ Part Time_____ Retired_____

Occupational Exposure: Chemicals___ Noise Exposure___ Physical Stress___Other_____

EXERCISE/ DIET

Do you exercise on a regular basis? Yes_____ No_____

If yes, how many times per week? _____ Type of exercise?_____

Diet (circle): Regular Diabetic Low Fat Low Salt Other_____

Caffeine Use: Yes_____ No_____ If yes, how many cups per day?_____

OTHER

Hobbies:_____

Do you use a seatbelt? Yes_____ No_____
Do you wear glasses or contacts? Yes_____ No_____
Do you wear hearing aids? Yes_____ No_____
Do you have a legal guardian or Healthcare Power of Attorney? Yes_____ No_____
If yes, who is your POA?_____
Do you have a living will or an Advanced Directives? Yes_____ No_____
If yes, please provide our office with a copy.
Do you have a DNR (Do Not Resuscitate) order? Yes_____ No_____
If yes, please provide our office with a copy.

MY CIRCLE OF CARE: In order to provide you with the best possible care that we are able, we ask that you provide us with a complete list of your other doctors as available. If you can provide phone numbers for the doctor's office, we would be appreciative.

Doctor Specialty	Doctor Name	Contact Information
Allergist		
Cardiologist		
Gastroenterologist		
Dermatologist		
Endocrinologist		
Geriatric Specialist		
Gynecologist		
Hematologist		
Nephrologist		
Neurologist		
Oncologist		
Ophthalmologist		
Orthopedic Surgeon		
Pain Management		
Plastic Surgeon		
Psychiatrist		
Pulmonologist		
Rheumatologist		
Urologist		
Podiatrist		

PAYMENT POLICY

Waypointe Internal Medicine, P.C. (the "Practice") intends to foster an open and respectful relationship between our providers, other health care practitioners and our patients. Our goal is to provide the best possible care and treatment for our patients. Part of providing the best possible care and treatment is communicating our payment and financial policy to you so that you understand what is expected. Although we are healthcare providers first and foremost, the Practice is also a business with employees, payroll, overhead and other expenses. Accordingly, the following provisions reflect our policy with respect to your financial obligations to the Practice:

1 **PAYMENT.** Payment is due at the time services are rendered. The Practice accepts cash, check, or debit and/or credit card payment. You are responsible for any unmet deductible, co-payment and/or co-insurance amounts, as well as any charges for items and services rendered which are not covered by your health insurance policy. If you do not have health insurance, payment in full for the items and services rendered is due at the time of service. Any balance for which you are responsible which is not paid at the time of service will be invoiced to you and must be paid within 30 days of the invoice.

2 **DOCUMENTATION**. The Practice requires and requests that you provide a driver's license or state identification card, as well as your health insurance card or other proof of insurance, and a current credit card to maintain on file. Proper identification is necessary to guard against identity theft and other fraud, while maintenance of current insurance information and credit card information promotes proper and timely payment. The Practice will maintain such information in strict confidence and will only provide access to such information to employees with a need to know. Otherwise, such information shall be safeguarded in accordance with applicable laws and regulations.

3 **INSURANCE.** You are responsible for knowing the nature and scope of your health insurance coverage. Please contact your health insurance provider if you have any questions about coverage and benefits. The Practice and its health care practitioners participate with and/or in many insurance companies and/or plans. It is possible that our practitioners are not participating providers with your particular company and/or plan. Further, it is also possible that some or all of the services the Practice provides at a given time may not be covered by your insurance company and/or plan. You will nevertheless be responsible for the payment of such items and services.

4 **ASSIGNMENT.** By your acknowledgment and execution of this Payment Policy, you agree to assign, transfer, and set over to the Practice the applicable benefits of insurance to which you are or may be entitled in order to pay for the care and treatment provided to you (or your dependent beneficiary).

5 **DELINQUENT ACCOUNT/NONPAYMENT**. In the event that payment is not made in accordance with this policy, and your account becomes past due by ninety (90) days, the Practice may engage a collection agency to pursue payment, among other remedies available to the Practice under the law. If your account is referred to collection, the Practice may discharge you as a patient of the Practice by written notice.

6 **ADDITIONAL FEES.** Additional reasonable fees incurred attendant with collection will be added to the outstanding balance and you agree to pay such additional fees, including but not limited to a $5.00 charge for each additional invoice sent after the initial invoice for charges for items and service rendered for which you are responsible. You will be charged $35.00 for any payment by check which is returned for non-sufficient funds. If you miss an appointment and/or cancel an appointment but fail to provide at least 24 hours prior notice, you may be charged a fee of $50.00. Any additional missed appointment or same day cancellation after the initial $50.00 fee will result in a $100.00 fee. We also reserve the right to discharge a patient for multiple missed appointments.

7 **ADDITIONAL ON CALL FEES.** Our physicians provide additional 24- hour call coverage for an additional fee. This is a service that we feel is an important resource for you and your family in urgent situations if you choose to use it. However, due to the time and costs involved with managing after- hours calls, you may be charged a flat rate of $ 50.00 per phone call and per patient assessment. This fee will not be billed to your insurance, but will be posted to your account at the Practice and as such, you will be personally responsible for the charge. This charge will not apply to calls due to errors on our part, such as prescriptions that did not transmit to the pharmacy. However, it will apply to situations such as your calling in a request for a prescription refill after hours.

8 **CONTACT US.** In the event that you have any questions about this policy and/or about any fees, charges and payment, you may contact our office or make an arrangement to meet with our staff in order to discuss any issues that may arise with respect to the payment for services rendered. Payment plans are available.

9 **COPIES AND FORMS.** Upon request, we will provide you with copies of medical records, subject to the following charges as provided under the Michigan Medical Records Access Act (charges are subject to annual adjustment based on statute).

Initial fee: $23.71 (if applicable)
Per page for the first 20 pages: $1.19
Per page from paged 21-50: $0.60
Per Page for pages 51+ : $0.23

You may be charged a reasonable cost-based fee for any request that the physicians complete documents while not in connection with an office visit in which health care items and services are provided.

I have read this Payment Policy and I understand and agree to be bound by the provisions set forth above, as the same may be amended and communicated to me from time to time.

_____ _____
Signature of Patient (or Guarantor) Date

_____
Print Name

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)**

1. Authorization

I, (patient's name) _____authorize the staff at Waypointe Internal Medicine, PC. to use and disclose the protected health information described below to

_____

(individual(s) seeking the information and their phone number)

2. Effective Period

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Date: _____ Signature of Patient:_____

Signature of Patient's Legal Representative (Guardian): _____

Relationship of patient's legal representative to the patient:
□ Spouse □ Father □ Mother □ Daughter □ Son □ Other: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 02, 2015 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Prior to making any significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations in accordance with applicable law in the following ways:

Treatment: We may use and disclose your health information to a physician, physician's assistant, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include certain activities that your health insurance plan may undertake before or after it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include appointment scheduling, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and conducting training programs, accreditation, certification, licensing or credentialing activities.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing services) for the practice. Whenever an arrangement between our facilities and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you provide us with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so, except as otherwise described in this Notice. Accompaniment implies your consent.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, our licensed staff shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our licensed staff is required by law to treat you and has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if our licensed staff attempts to obtain consent from you but is unable to do so due to substantial communication barriers and our licensed staff determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Marketing Health-Related Services: We will not use your health information for marketing communications or make disclosures that would constitute a sale of PHI without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security and Correctional Facilities: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose protected health information to correctional institution or law enforcement officials having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies, government benefit programs, other government regulatory programs and civil rights agencies.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may also disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR Section 164.500 et. seq.

YOUR RIGHTS

Access: You have the right to look at or receive copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you depending on the number of pages being copied per the Michigan Medical Record Copying Fee Act. If you request an alternative format or films or videotapes, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Electronic Access: You have the right to access protected health information in an electronic format if we maintain protected health information in such format, subject to a reasonable cost-based fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests. For electronic health records, the list of disclosures is limited to the last 3 years but applies to all disclosures made by us regardless of purpose.

Breach Notification: You have the right to be notified in the event of a breach of your unsecured PHI in the event one occurs, which such notification will be made directly to you or by alternative means as permitted by applicable law and regulations.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but, if we do agree, we will abide by our written agreement signed by you and us (except in an emergency). We are required to agree to a request for restriction if it relates to a disclosure to a health plan for purposes of carrying out payment or health care operations and the PHI pertains solely to a healthcare item or service for which we have been paid by you out-of-pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may submit a complaint to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Bethany Ward

Telephone: (586) 778-1881 Fax: (586) 778-0667

E-mail: bward@waypointemedicine.com

Address: 24400 Greater Mack St. Clair Shores, MI 48080

Receipt of Notice of Privacy Practices

Patient Name:_____ Date:_____

By signing below, I acknowledge that I have received a copy of Waypointe Internal Medicine, P.C.'s Notice of Privacy Practices. I understand that this document provides and explanation of the ways in which my health information may be used or disclosed by Waypointe Internal Medicine, P.C. and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ _____

Patient Signature Date

_____ _____

Witness Date

TO COMPLETED BY ADMITTING CLINICAL STAFF IF FORM IS NOT SIGNED

1. Was the client provided with a copy the agency's Notice of Privacy Practices?
Yes_____ No_____

2. Briefly Describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient we not able or willing to sign this form.

_____

Staff Member Date

Waypointe
Internal Medicine, PC

24400 Greater Mack Avenue
St. Clair Shores, MI 48080
Phone: (586) 778-1881 Fax: (586) 778-0667

Patient-Provider Agreement

Our goal is to provide you with the highest standard of healthcare. The only way we can meet this goal is if I, your medical provider, and you, my patient, work together. This concept is called **Patient Centered Medical Home** and the following outlines the responsibilities of the patient and medical provider partnership:

Patient

- 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 medical provider about any changes in your health and well-being
- Take all of your medicine and follow your medical provider's advice
- Keep all appointments as directed by your medical provider or reschedule if necessary
- Call your medical provider first with all problems, unless it is a medical emergency
- Ensure you have a clear understanding of the plans you and your health care team have laid out for you during your visit
- Respect and honor the financial arrangements through your insurance carrier and the medical home

Medical Provider

- Establish a strong link with the patients that encourage open and honest discussions regarding your health and associated care plans
- Provide 24 hour access to medical care and same day appointments, whenever possible
- Give my patients clear directions about medications, testing, and other treatments
- Care for all stages of life including acute care, chronic care, preventative care and end of life care
- Accomplish care by establishing health maintenance plans for patients with chronic conditions
- Direct and coordinate all elements of care in the complex health system through any necessary referrals to specialists, hospitalizations, home health agencies and the community

Thank you for selecting us as your Patient-Centered Medical Home!

WAYPOINTE INTERNAL MEDICINE, P.C.

24400 Greater Mack Avenue, St. Clair Shores, MI

Thank you for partnering with our office and taking an active role in your health. In order to enhance our partnership, it is important we share some helpful practice information.

Our **office hours** are **Monday, Tuesday, Wednesday, Thursday, 8:00 am – 5:00pm and Friday** from **8:00 am to 4:00** pm. **Monday – Thursday** our phones are on from **9:00 am to 4:30 pm** and **Friday** from **9:00 am to 3:30 pm**.

After hours you are instructed to call your the provider on-call:

Waypointe Internal Medicine After Hours Line: (586)360-0853

PLEASE CALL DURING BUSINESS HOURS FOR PRESCRIPTION REFILLS

We have developed partnerships with three urgent cares for when our office is closed and it is **NOT** a life threatening emergency, they will forward their medical findings to us the following day.

St. John Eastside Pediatrics/Adult Urgent Care
21000 E. 12 Mile Road (E of I-94)
Suite 105 St. Clair Shores, MI
586-498-3606
Hours: Monday-Friday 5:00 pm to 10:00 pm Sat & Holidays 12:00 pm to 6:00 pm Sunday 10:00 am to 5:00 pm

Shores Urgent Care
25631 Little Mack
St. Clair Shores, MI
586-884-2727
Hours: Everyday including Holidays 8:00 am to 9:00 pm

Grosse Pointe Urgent Care
20311 Mack Avenue
Grosse Pointe Woods, MI
313-499-6000
Hours: Everyday including Holidays 8:00 am to 10:00 pm

ANY LIFE THREATENING EMERGENCY YOU SHOULD DIAL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM

After any visit to the urgent care, emergency room or hospital, it is very important for us to see you for a follow-up appointment, please please contact our office at 586-778-1881