

Arshad Aqil MD PLLC
1070 E Caro Rd Ste 1
Caro, MI 48723
989-672-0341
New Patient Packet Checklist:

- PLEASE BRING WITH YOU TO YOUR APPOINTMENT:**
 - Photo Identification
 - Insurance Card(s) - IF HMO, MUST CHANGE PCP TO DR AQIL PRIOR TO YOUR APPOINTMENT
 - All Medication (PRESCRIBED AND OVER THE COUNTER) in their original containers
 - Arrive 15 minutes early for registration

- Emergency Room Department Usage Policy (1 page)

- Local Urgent Care Clinic Hours and usage (1 page)

- Patient Registration Information (2 pages, signature needed)

- Patient History Information (3 pages, signature needed)

- Social Drivers of Health (SDoH) (3 pages)

- Patient Health Questionnaire (PHQ-9) (1 page)

- Gad 7 - Anxiety Questionnaire (1 page)

- Bladder Control Assessment Tool (Age 30 yr +) (1 page)

- Patient Centered Medical Home-PCMH (1 page, signature needed)

- HIPAA - Patient Consent of Information (1 page, signature needed)

- HMO MANAGED CARE PATIENTS ONLY** - Health Managed Organization-HMO agreement (1 page, signature needed)

UPDATED 2025/9/23
Arshad Aqil MD PLLC
1070 E Caro Rd Ste 1
Caro, MI 48723

EMERGENCY ROOM DEPARTMENT USAGE POLICY

This policy is in place to ensure the most appropriate utilization of the emergency room.

POLICY:

If you feel that you need to go to the emergency room for any reason, please contact the office first. If you are unable to talk to the office staff for any reason after failed attempts during office hours, please contact the answering service. If it is after office hours or on the weekend, the answering service can be connected through the office phone number and Dr Aqil can be paged. This is to ensure that the office is given the opportunity to provide you with care that meets your needs and fits with your goals and values. Our role as your Primary Care Provider, is to manage your health status, including well being and preventative care, and treatment for acute and chronic disease management.

In the event of a **life threatening medical emergency** however (Symptoms of Heart Attack, Stroke, Chest Pain, Broken Bone, Seizure, bleeding that won't stop, deep cuts or severe burns Etc...), please go to the nearest emergency room immediately.

An **urgent condition** (Skin rashes, minor cuts with controlled bleeding, Colds, Coughs, Flu Symptoms, Shortness of Breath, Chest congestion, Headache, ANY body pain, Urinary tract infection, dizziness, vomiting Etc...) should be treated by Dr Aqil himself, whether it be in office or through the answering service after hours.

PLEASE SEE THE REVERSE SIDE FOR LOCAL AFTER URGENT CARE CLINIC HOURS INFORMATION.

LOCAL URGENT CARE CLINIC HOURS

Updated 2025/4/30

PLEASE CALL THE OFFICE FIRST AT 989-672-0341 FOR ANY URGENT NEEDS.
AFTER HOURS **PLEASE CALL THE OFFICE 24 HOUR ANSWERING SERVICE AT 989-583-2396 PRIOR TO AN URGENT CARE OR ER VISIT**

Hills and Dales Urgent Care - NO HMO PATIENTS

Monday-Thursday 3p-8p, Friday 1p-8p, and Saturday-Sunday 9a-2p
4675 Hill St Cass City, MI 48726//989-912-6114

Hills and Dales Rapid Care - NO HMO PATIENTS

Monday-Saturday 7a-7p, Closed Sundays
1048 E Caro Rd, Caro, MI 48723// (989) 912-6532

Caro Quick Care IS PERMANENTLY CLOSED

Scheurer Health FastCare - located inside of Meijer - NO HMO PATIENTS

Monday-Friday 8a-8p
100 Pigeon Rd, Bad Axe, MI 48413//(989) 623-9505

(ALL HMO PATIENTS MUST GO TO ONE OF THE BELOW)

Covenant Healthcare MedExpress

Monday-Saturday 8a-7:30p, Sunday 9a-5:30p, HOLIDAYS 9a-2:30p
600 N Main St, Frankenmuth, MI 48734//989-652-1320
2919 East Wilder Rd, Bay City//989-671-5700
5570 State St, Saginaw//989-583-0100
2970 Pierce Rd, Saginaw//989-583-0285
16440 Gratiot Rd, Hemlock//989-583-0670

URGENT CARE

- Respiratory virus and flu
- Ear, sinus and throat infections
- Vomiting and diarrhea
- Mild to moderate dehydration
- Mild to moderate asthma
- Rashes and allergic reactions
- Sprains, strains and simple fractures
- Minor burns and cuts
- Mild injuries
- Animal and insect bites/stings
- Eye injuries/pink eye
- Sports injuries

EMERGENCY DEPARTMENT

- Chest pain, shortness of breath, nausea
- Sudden, severe headache
- Severe abdominal pain
- Loss of consciousness or speech
- Limb numbness
- Motor vehicle injury
- Head or neck injury
- Seizures
- Psychiatric disorders
- Overdoses
- Child abuse
- Assault including rape
- Bleeding/cramping in pregnancy

ARSHAD AQIL MD PLLC
PATIENT REGISTRATION INFORMATION (1 of 2)

Name: _____
(Last name) (First name) (Middle Name)

Date of Birth: _____ Social Security #: _____

Name Preference: _____ # of Children: _____

Address: _____
(Apt#) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status: Single Married Widowed Divorced
 Legally Separated Significant Other

Social Support: Caretaker for disability Family Network Isolation
 Single Parent Other _____

Gender Identity: Male Female
 Transgender Male/Female Non-binary Other

Sexual Orientation: Male Female
 Transgender Male/Female Non-binary Other

Patient Race: American Indian Asian African American Hispanic
 White/Caucasian

Other _____

Primary/Preferred Language: _____

Health Literacy Limitations: Low Educational Attainment Cognitive Impairment
 Language Barrier

Other _____

Refugee: Yes No Other Not Applicable

Employment Status: Full Time Part Time Retired Volunteer
 Disabled Not Employed Self Employed

Other _____

Military Status: Active Duty Reserve Veteran Not Applicable

Level of Education status: High School/GED Some College Associates Degree
 Bachelors Degree Masters Degree Doctorate Degree

ARSHAD AQIL MD PLLC
PATIENT REGISTRATION INFORMATION (2 of 2)

Employer: _____

Occupation: _____ **Phone:** _____

Spouse Name: _____ **Phone:** _____

Parent/Legal Guardian: _____

Home Phone: _____ **Cell Phone:** _____

Emergency Contact (other than spouse/Parent): _____

Address: _____
(Apt#) (City) (State) (Zip)

Relationship: _____ **Cell Phone:** _____

Primary Insurance: Check if Uninsured

Insurance Name: _____

Insurance ID: _____ **Group:** _____

Policy Holder: _____ **Date of Birth:** _____

Relationship to Patient: _____

Secondary Insurance:

Insurance Name: _____

Insurance ID: _____ **Group:** _____

Policy Holder: _____ **Date of Birth:** _____

Relationship to Patient: _____

I hereby consent and authorize the administration of such medical and/or surgical procedures which are necessary or advisable by the clinic. I hereby give lifetime authorization for payment of insurance benefits to be made directly to Arshad Aqil MD PLLC and any assisting physician for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorneys fees. I hereby authorize this healthcare provider to release

information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

ARSHAD AQIL MD PLLC
 PATIENT HISTORY INFORMATION (1 of 3)

Name: _____
 (Last name) (First name) (Middle Name)

Date of Birth: _____ Social Security #: _____

Listed below are common medical conditions. If either YOU or a FAMILY MEMBER has now or has ever had in the past any of these conditions, please check the appropriate box. Next to each condition please list the name of the individual who has/had the condition.

Self	Family	Condition	Self	Family	Condition
		Breast Cancer			Hepatitis
		Cervical Cancer			Arthritis
		Prostate Cancer			Back Problems
		Colon Cancer			Hearing Problems
		Skin Cancer			Dental Problems
		Other Cancer			Skin Problems
		Heart Attack			Kidney problems
		Heart Bypass Surgery			Change in Bowels
		Heart balloon Surgery			Blood in Stool
		Leg Swelling			Dark Tarry Stools
		Stroke			Sexually Transmitted Disease
		High Cholesterol			Depression
		Diabetes			Panic Attacks
		High Blood Pressure			Chicken Pox
		Emphysema			Mononucleosis
		Asthma			Measles
		Lung Problems			Mumps
		Seizures			Migraine Headaches

Please list MONTH and YEAR of your most recent Immunization

____/____ Hepatitis A	____/____ Flu Shot	____/____ MMR
____/____ Hepatitis B	____/____ Covid19	____/____ Pneumonia

_____/_____/_____ Chicken Pox	_____/_____/_____ Tetanus	_____/_____/_____ Other
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ARSHAD AQIL MD PLLC
PATIENT HISTORY INFORMATION (2 of 3)

Please if you have now or have had in the past any habits listed below and amount:

Habit	Type	Amount	Habit	Type	Amount
Illicit Drugs			Alcohol		
Caffeine			Tobacco		
Seat Belt Use			Exercise		

Please BRING INTO THE OFFICE ON THE DAY OF YOUR APPOINTMENT all medications you are taking including PRESCRIPTIONS, VITAMINS, and HERBAL SUPPLEMENTS in their ORIGINAL CONTAINERS.

Please list the Pharmacy(s) that you use:

1.
2.

Please list any surgeries that you have had:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Please list all the medications you are allergic to and what happens if you take it:

1.	3.
2.	4.

For **DIABETICS** please fill in the following dates and information

Last Hemoglobin A1c Date:_____ Result:_____ Facility:_____
Last Microalbumin Date:_____ Result:_____ Facility:_____
Last DM Foot Exam Date:_____ Facility:_____
Last Dm Eye Exam Date:_____ Provider:_____

ARSHAD AQIL MD PLLC
PATIENT HISTORY INFORMATION (3 of 3)

For **WOMEN** please fill in the following dates and information:

Number of Pregnancies _____ Children _____ Miscarriages _____ Abortions _____
Last Pap Smear(Age 21-64) Date: _____ Provider: _____
Ever had an abnormal Pap: _____ Method of Birth Control: _____
Currently Pregnant: _____ Date of last Period: _____
Last Mammogram (Age 40-74) Date: _____ Facility: _____
Last Colonoscopy (Age 50-75) Date: _____ Facility: _____
Last Bone Density (Age 65+) Date: _____ Facility: _____

For **MEN** please fill in the following dates and information:

Last Colonoscopy (Age 50-75) Date: _____ Facility: _____
Last Bone Density (Age 65+) Date: _____ Facility: _____
Last PSA (blood prostate level) (Age 50+) Date: _____
Prostate Problems: _____ Weak Urine Stream: _____
Lumps on Testicles: _____ Pain on Testicles: _____

Do you have an ADVANCED DIRECTIVE: _____

ACKNOWLEDGMENT:

Your signature below indicates that you have read and answered all of the questions to the best of your knowledge:

Patient Signature: _____ Date: _____

Arshad Aqil MD
Social Drivers of Health (SDoH)
Updated 2024/10/25

Patient Name: _____ DOB: _____ Date: _____

Please Circle the most appropriate answer

1: On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?

0	1	2	3	4	5	6	7
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2: On average, how many minutes do you engage in exercise at this level?

0-10	20-30	40-50	60-70	80-90	100-110	120-130	140+
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3: How hard is it for you to pay for basics like food, housing, medical care and heating?

Very Hard	Hard	Somewhat hard	Not very hard	Not hard at all
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4: In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

Yes	No
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5: In the last 12 months, how many times have you moved where you are living?

1	2	3	4	5+
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6: At any time in the past 12 months, were you homeless or living in a shelter (including now)?

Yes	No
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7: In the last 12 months, has a lack of transportation kept you from medical appointments or from getting medications?

Yes	No
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8: In the last 12 months, has lack of transportation kept you from meetings, work or from getting things you need for daily living?

Yes	No
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9: Within the last 12 months, you worried that your food would run out before you got the money to buy more.

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Never true	Sometimes true	Often true
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10: Within the last 12 months, the food that you bought just didn't last and you didn't have money to get more.

Never true	Sometimes true	Often true
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11: In the last 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

No	Yes	Already shut off
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12: How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never	Rarely	Sometimes	Often	Always
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13: Do you feel stressed- tense, restless, nervous or anxious, or unable to sleep at night because your mind is troubled all the time?

Not at all	Only a Little	To some extent	Rather much	Very Much
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14: In a typical week, how many times do you talk on the phone with family, friends or neighbors?

Never	Once a week	Twice a week	Three times a week	Greater than 3 times week
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15: How often do you get together with family or relatives?

Never	Once a week	Twice a week	Three times a week	Greater than 3 times week
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16: How often do you attend church or religious services?

Never	1-4 times a year	Greater than 4x year
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17: Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups or school groups?

Yes	No
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18: How often do you attend meetings of the clubs or organizations you belong to?

Never	1-4 times a year	Greater than 4 times year
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19: Are you married, widowed, divorced, separated, never married or living with a partner?					
Married	Widowed	Divorced	Separated	Never married	Living with a partner

20: Within the last year, have you been afraid of your partner or ex-partner?	
Yes	No

21: Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	
Yes	No

22: Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	
Yes	No

23: Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	
Yes	No

24: How often do you have a drink containing alcohol?				
Never	Monthly or less	2-4 times a month	2-3- times a week	Greater than 4 times a week

25: How many drinks containing alcohol do you have on a typical day when you are drinking?					
0	1 to 2	3 to 4	5 to 6	7 to 9	10 or more

26: How often do you have 6 or more drinks on one occasion?				
Never	Monthly or less	Monthly	Weekly	Daily or almost daily

27: We make community resources available to all of our patients to assist with everyday needs. We may be able to connect you with those resources. Would you be interested?	
Yes	No

28: Would you like to receive assistance with any of these needs?	
Yes	No

29: Are any of your needs urgent?	
Yes	No

Arshad Aqil MD PLLC
 PATIENT HEALTH QUESTIONNAIRE (PHQ-9)
 Updated 2024/1/4

Name: _____ DOB: _____ DATE: _____

Over the LAST 2 WEEKS , have you been bothered by any of the following problems?				
Question:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed OR the opposite, being fidgety or restless?	0	1	2	3
9. Thought that you would be better off dead or thoughts of hurting yourself?	0	1	2	3
10. Suicidal thoughts, attempts, OR plans?	0	1	2	3
11. If you checked off any problems, 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?	Not Difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult

FOR INTERNAL USE ONLY:				
First PHQ9: Yes _____, No _____				
TOTAL SCORE: _____, Last Score: _____				
1-4 Minimal	5-9 Mild	10-14 Moderate	15-19 Moderate/Severe	20-27 Severe

Negative, Same Medication, Medication Adjustment, Referral, Positive but Negative, New Medication

GAD-7 Anxiety

Over the last two weeks , how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid, as if something awful might happen				

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Arshad Aqil MD PLLC
 Bladder Control Assessment Tool (AGE 30 yr +)
 Updated 2024/2/20

Name: _____ DOB: _____ Date: _____

Do you have issues with urine leakage?	YES	NO
IF NO-screening is complete. If YES, PLEASE continue with remaining questions:		
Do you experience urine leakage with coughing, laughing or sneezing?	YES	NO
Do you experience urine leakage when you feel the urge to urinate?	YES	NO
Do you experience urine leakage as a result of childbirth?	YES	NO
Do you experience urine leakage as a result of a surgical procedure?	YES	NO
How many times do you wake up during the night to urinate?	1 time 2 times 3 times 4 times 5 or more times	
How often do you feel the urge to urinate during the day in a 24 hour period?	1-6 times 7-8 times 9-10 times 11-12 times 13-14 times 15 or more times	
Are you ever NOT able to urinate?	YES	NO
Do you have difficulty with starting your urine stream?	YES	NO

Arshad Aqil, MD PLLC

1070 E Caro Rd Ste 1, Caro, MI 48723 Phone: 989-672-0341

PATIENT CENTERED MEDICAL HOME (PCMH) Patient / Provider Agreement

Good communication between patients and physicians is the key to better outcomes. My staff and I are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

Our Responsibilities to You:

- **Respect you as an individual** – we will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information
- **Respect your privacy** – your medical information will not be shared with anyone else unless you give permission or as required by law; please be aware that while providing comprehensive, quality care we will share medical information with other providers who are involved in your care, as necessary.
- **Provide the best possible treatment and advice based on current medical evidence** – we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
- **Manage your health status**, including well care, preventive care as well as treatment for acute and chronic diseases
- **Provide you timely access to care** in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed.

What We Ask of You:

- **Ask questions**, share your feelings and be part of your care
- **Be honest about your history**, symptoms and other important information about your health
- Tell your doctor about any changes in your health and well-being
- Take your medicine as ordered and follow your doctor's advice-if you are not willing or able to do so, be honest with the doctor
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- **Call your doctor first with all problems, unless you have a medical emergency**
- End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans
- **Inquire about community service information related to your health and wellness needs**
- If medical services or community services are performed outside of this office, request all information be sent here

PLEASE NOTE: Our office hours are Mon, Tues and Thurs. 8am-4:30pm, Wed 8a-4p, and Fri 8a-12p. When the office is closed, we have an answering service 989-583-2396 that will contact me or the physician on call, so any medical issues that cannot wait until regular office hours can be addressed. It is important that you keep all scheduled appointments and notify us sufficiently in advance if you need to cancel or reschedule an appointment. **We also offer same day appointments during regular office hours.**

Urgent or Emergent Care: Please attempt to call our office at the number above before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention. *By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. Lack of proper participation could lead to discharge from the practice with a 30 day notice.* This is not a legally binding contract but is intended to provide a framework upon which we can build a *relationship that will allow you to maximize your health status in a comfortable and welcoming environment.*

PRINT Patient Name

Patient or Representative signature

Date

Physician or Representative Signature

Date

Arshad Aqil MD PLLC

HIPAA - Patient Consent of Information (Revised 1/23/2026)

I, the patient, authorize Arshad Aqil MD PLLC and its staff to leave messages containing **Protected Health Information (PHI)** regarding scheduling, treatment, surgery, lab/radiology results, or other necessary information on an answering machine, voicemail, or with a specified individual. I understand that without this authorization, only minimal information (name, number) will be left. I may specify details and recipients below. I also consent to the mailing/faxing of requested results to my primary care physician or other involved providers.

To protect your privacy, HIPAA laws prevent us from sharing your medical records, billing details, or appointment information with anyone other than you, unless you give us written permission. If you would like to allow a spouse, family member, or friend to access your information - such as picking up documents, discussing care, or asking billing questions, please fill out below:

Name of Spouse, Family member, or Friend to Release PHI	Relationship	Phone number
1)		
2)		
3)		

Health Information to be disclosed upon the request of the person named above:

(CHECK EITHER “A” OR “B”)

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, Mychart access, and billing, for all conditions)

OR

B. Disclose my health record, as above, **BUT DO NOT DISCLOSE THE FOLLOWING:** (check as appropriate):

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

Authorization for Consent of Information and Acknowledgement for Privacy Practice

HIPAA – Notice of Privacy Practice Acknowledgement:

Please “check” if you would like a copy of Arshad Aqil MD PLLC Privacy Practice.

Patient's Name (PRINT): _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Arshad Aqil MD PLLC
1070 E Caro Rd Ste 1
Caro, MI 48723

IMPORTANT INFORMATION FOR OUR HMO MANAGED CARE PATIENTS ONLY

I am pleased you have chosen me as your Primary Care Physician (PCP). I am providing you with this information so you may better understand how my office operates, what services I can provide to you, and your role in creating a partnership that will manage all of your healthcare needs through your health insurance coverage.

I (or one of my associates) will be readily available 24 hours a day, 7 days a week, to help you make the best use of our complex healthcare system and to provide primary care services. Many services covered by your insurance plan require that I initiate the order or the referral. If a service is not authorized or not ordered by me, it may not be paid by your insurance plan.

Please read each item below to help you understand the way your HMO insurance works.

Before going to any other physician you **MUST** contact my office staff to get a referral. The only exception is for female patients who visit an Obstetrician/Gynecologist for an annual physical or routine obstetrical care.

Before going to any other healthcare facility (such as a hospital, laboratory, x-ray, or physical therapy) you **MUST** see or contact me for any appropriate authorization. ***Exception - In the event of a true medical emergency go directly to COVENANT HEALTHCARE EMERGENCY IMMEDIATELY!**

If you are unable to reach me or my staff in the office for any reason, you must contact me through our answering service at 989-583-2396 (available 24 hours day/7 days week)

There will be no "Backdated" referrals to specialists or facilities. A referral **MUST** be obtained from me before the service is provided.

You must contact me before going to an Urgent Care, Emergency Department, Hospital, or any outpatient medical facility. ***Exception - In the event of a true medical emergency go directly to COVENANT HEALTHCARE EMERGENCY IMMEDIATELY!**

Please make sure that if, beyond your circumstances you are seen at another Emergency department other than Covenant Healthcare for a true emergency and need to stay in the hospital, that you or your family contact me so I can arrange a transfer to Covenant Healthcare if appropriate medically at the time you are in the emergency Department.

I am affiliated with Covenant Hospital and **MOST** of your care will occur there. If Covenant does not offer a particular service, I will authorize care at a facility that does offer that service.

I practice Evidence Based Medicine. That means I conduct a careful analysis of the treatment options on your individual medical background and situation. I do not prescribe medications, make referrals, or order tests when not medically indicated. **Please understand that all requests may not be approved.**

Failure to contact my office and/or receive a referral or authorization to go to any physician, facility, or location where medical care is rendered, could mean you may have to pay for that service yourself.

Please let me know if you have any questions about understanding the way your HMO insurance works.

Patient Name: _____

DOB: _____

Signature: _____

Date: _____

HMO MANAGED CARE PATIENTS ONLY