Arshad Aqil MD
1070 E Caro Rd Suite 1
Caro, MI 48723
989-672-0341

PLEASE BRING
- Photo Identification
- Insurance Card(s)
- Medication in original containers
- arrive 15 minutes early for registration

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 HOURS/EXTENDED HOURS CLINIC INFORMATION.

LOCAL AFTER HOURS/EXTENDED HOURS CLINICS
Updated 2023/7/6
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 Extended Hours Clinic
Monday-Thursday 3p-8p, Friday 1p-8p, and Saturday-Sunday 9a-2p
4675 Hill St Cass City, MI 48726//989-912-6114

Caro Quick Care IS PERMANENTLY CLOSED

Scheurer Health FastCare - located inside of Meijer
Monday-Friday 8a-8p, Saturday 10a-6p -Sunday 12p-4p
100 Pigeon Rd, Bad Axe, MI 48413//(989) 623-9505

(ALL HMO PATIENTS MUST GO TO ONE OF THESE BELOW)
Covenant Healthcare MedExpress
Monday-Saturday 8a-8p, Sunday 9a-6p, HOLIDAYS 9a-3p (Closed Christmas Day)
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
3360 Tittabawassee Rd, Saginaw//989-583-0310

URGENT CARE	EMERGENCY DEPARTMENT
• 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	• 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

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

Date of Birth:_____ Social Security #:_____

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

Home Phone:_____ Cell Phone:_____

Marital Status: ___Single ___Married ___Widowed ___Divorced ___Legally Separated

Name Preference:_____ Children:_____

Gender Identity: ___ Male ___Female ___Transgender Male/Female ___Non-binary ____Other

Patient Race:_____

Employer:_____

Occupation:_____ Phone:_____

Employment Status: ___Full Time ___Part Time ___Retired ___Volunteer ___Other

Spouse:_____ Phone:_____

Parent/Legal Guardian:_____

Home Phone:_____Cell Phone:_____

Emergency Contact (other than spouse/Parent):_____

Address:_____
(Apt#) (City) (State) (Zip)
Relationship:_____ Cell Phone:_____

Policy Holder:_____ Date of Birth:_____
Insurance Name:_____ Relationship to Patient:_____
Insurance ID:_____ Group:_____

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. Ihereby 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

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 list all medications you are taking including vitamins and herbal supplements

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

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 HemaglobinA1c 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:_____

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

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:_____ DOB:_____ DATE:_____
First PHQ-9 of year: YES NO Last Score:_____

OVER THE **LAST 2 WEEKS**, HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?				
	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. THOUGHTS 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
			Score:	
Negative/Same Medication/ Medication Adjustment/Referral/Positive but Negative/New Medication				

1-4 Minimal 5-9 Mild 10-14 Moderate 15-19 Moderate/Severe 20-27 Severe

[1]Social Determinants of Health (SDoH)

Patient Name:_____ DOB:_____ Date:_____

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**
On average, how many minutes do you engage in exercise at this level? **0 10 20 30 40 50 60 70 80 90 100 110 120 130 140 150+**
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**
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? **Yes No**
In the last 12 months, how many places have you lived? **1 2 3 4 5+**
In the last 12 month, was there a time that you did not have a steady place to sleep or slept in a shelter (including now)? **Yes No**
In the last 12 month, has a lack of transportation kept you from medical appointments or from getting medications? **Yes No**
In the last 12 month, has lack of transportation kept you from meetings, work or from getting things you need for daily living? **Yes No**
Within the last 12 month, you worried that your food would run out before you got the money to buy more. **Never true Sometimes true Often true**
Within the last 12 month, the food that you bought just didn't last and you didn't have money to get more. **Never true Sometimes true Often true**
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**
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 more than three time a week**
How often do you get together with family or relatives? **Never once a week twice a week three times a week more than three time a week**
How often do you attend church or religious services? **Never 1-4 times a year more that 4 times a year**
Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups or school groups? **Yes No**

[1] FLIP OVER 1 of 2

How often do you attend meetings of the clubs or organizations you belong to? **Never 1-4 times a year more that 4 times a year**
Are you married, widowed, divorced, separated, never married or living with a partner? **Married widowed divorced separated never married living with a partner**
Within the last year, have you been afraid of your partner or ex-partner? **Yes No**
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? **Yes No**
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? **Yes No**
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**
How often do you have a drink containing alcohol? **Never Monthly or less 2-4 times a month 2-3- times a week 4 or more times a week**
How many drinks containing alcohol do you have on a typical day when you are drinking? **1-2 3-4 5-6 7-9 10 or more**
How often do you have 6 or more drinks on one occasion? **Never Monthly or less Monthly Weekly Daily or almost daily**
Would you like to receive assistance with any of these needs? **Yes No**
Are any of your needs urgent? **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**
- **I**f 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**. 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

Arshad Aqil MD PLLC, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Arshad Aqil MD PLLC from violating the patient' s confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Arshad Aqil MD PLLC physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Arshad Aqil MD PLLC physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ via text message

_____ on an answering machine or voicemail at home or cell phone

_____ on an answering machine or voicemail at work

_____ with_____ Relationship_____

_____ with_____ Relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

Patient's Name (Please Print):_____Date of Birth:_____

Patient's Signature:_____Date:_____

<u>HIPAA – Notice of Privacy Practice Acknowledgement</u>

_____I have been provided/offered a copy of Arshad Aqil MD PLLC Privacy Practice.

_____I have declined a copy of Arshad Aqil MD PLLC Notice of Privacy Practice.

Patient's Signature:_____Date:_____

Arshad Aqil MD PLLC
HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact information: _____

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, 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): _____ _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
_____ An electronic record or access through an online portal
_____ Hard copy

This authorization shall be effective until (**Check one**):
_____ All past, present, and future periods, **OR**
_____ Date or event:_____
unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Today's 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 (available24 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