Grand Traverse Internal and Family Medicine, PC
5015 N. Royal Dr., Traverse City, MI 49684

David E. Oakley, M.D.
Charles R. Klettner, M.D.
Marci R. Bultemeier, D.O.

Judith M. Yates, M.D.
Elizabeth L. Hughes, D.O.
Mary Douglas, PA-C

Welcome to Grand Traverse Internal and Family Medicine, P.C.

Your Patient Centered Medical Home (please see brochure)

The following is information that you will find helpful as you join our practice:

We provide you with convenient 24/7 access to your medical records from the privacy of your computer or smart phone through our **Patient Portal.** (Secure login access.)

First Visit: (print from our website) www.gtinternists.com /forms/New Patient Packet

- Fill out the ***Patient Registration*** and ***Medical History*** forms and bring them with you.
- Bring your insurance cards (required at every visit).
- Bring your driver's license.
- Bring your current prescription bottles so we can record them accurately.
- Bring your vaccination history with you.
- Review your insurance coverage to determine your benefits **BEFORE** the appointment.
- Co-Pays and deductible are due at the time of service.

Our Hours:

- Office Hours: Monday ~ Friday 8:00 a.m. to 5:00 p.m.
- Lab Hours: Monday ~ Friday 7:30 a.m. to 4:30 p.m. (closed 12:30 to 1:30 p.m.)
- Phone Hours: Monday ~ Friday 8:00 a.m. to 4:00 p.m. (closed 12:30 to 1:30 p.m.)

Scheduling:

- Call **231-935-0850** or request an appointment through your **patient portal** to schedule.
- Please talk to the receptionist to make appointments.
- Speak with the clinical assistant to discuss current health concerns.
- Please call us if you are unable to keep your appointment. (24-hour notice)
- If you need to be seen urgently, we will try to schedule you with your primary care physician. If that is not possible, we will offer you an appointment with one of the other Physicians or the PA in the practice.

After Hours:

- If you have an **Emergent** condition, please call **911**.
- If you have an **urgent** condition, please call 231-935-0850 to reach our on-call physician.

Prescription Refills:

- Please request your prescription refills at your office visits.
- Request through the **patient portal** is preferred. (Login access required)
- We may take up to 24 hours to call in your refill—please plan accordingly.

Financial Arrangements:

- See our ***Financial Policy*** for complete details.
- Charges not covered by your insurance are due at the time of service.
- You are fully responsible for any portion of your bill that is denied or otherwise not paid by your insurance carrier.
- Our billing office can work with you to set up a payment plan, if needed. 231-709-6196
- Once a claim has been sent to your insurance, we will not change the billing.

Revised 09/2021

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Financial Policy

Thank you for choosing us as your primary care provider. Your care is a partnership between yourself and your provider, and we are committed to providing you with quality and affordable health care. Please read below, ask any questions you may have, and the Front Desk Receptionist will have you sign an acknowledgement at your initial visit.

Help Us to Help You:

- Check your insurance policy to see if you have coverage for preventative or wellness visits.
- Please present insurance cards at every visit, including lab visits.
- Please inform us of changes in insurance, address, phone number and marital status.
- Insurance, demographic changes and payments can also be made on our secure **Patient Portal** (Your account will be web-enabled when your appointment has been scheduled). The **Patient Portal** will require a user name and password.

Laboratory Billing

- If you have laboratory work drawn in our office lab, it will be billed to your insurance company.
- The lab balance for that visit is usually not included in the balance when you check out.
- Some lab work is sent to Munson Medical Center for processing. You may receive a bill from them.
- Some lab work is further sent to Mayo Laboratories, and you may receive a bill from them.

Payment:

- **Payment is due at the time of service.**
- We accept cash, checks, money orders, and most major credit cards.
- Our billing office will work with you to set up a payment plan, if needed.
- We charge $30 for checks returned due to insufficient funds or closed accounts.
- We charge $30 for accounts sent to collections
- We reserve the right to charge a fee on unpaid balances.
- We reserve the right to charge a missed appointment fee.
- We reserve the right to charge for items mailed to you.

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**** Please do not ask us to change our billing due to a denial from your insurance; we will not change CPT or Diagnosis codes. Making changes to billing after it has been submitted to insurance may be considered fraud. ****

Non-Covered Services:

- Please be aware that some – and perhaps all – of the service you receive may be non-covered or not considered reasonable or necessary by your insurance company. The provider's decision to order tests, x-rays, labs and any other medical services is based on your health care needs, not your insurance coverage. It is your responsibility to know your insurance coverage before any services are rendered.

No Insurance Coverage:

Visit must be paid for at the time of service. A discount will apply.

Medicare:

- If you have coverage under Medicare Part B, we will submit the claim to Medicare on your behalf.
- You are responsible for co-pays and non-covered services.

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Priority Health, BCBS, BCN, Aetna, Humana, United Health Care

- Contact your insurance carrier to find out the amount of your deductible, co-payment, co-insurance and coverage prior to your visit*, as that amount is due at the time of service.*
- Your co-payment is due at the time of service.

Tricare Select

- We are credentialed as non-network providers. We are able to see military members who have the Select plan (PPO) if they choose to use a non-network provider. Which means there will be a higher cost share.

Medicaid:

- We will submit your claim to Medicaid. You are responsible for any co-payment or spend down amounts. We participate with straight Medicaid and Meridian Medicaid only.

Secondary Insurance Coverage:

- If you have a secondary or supplemental policy and have provided us with that information, we will bill them once as a courtesy.

The patient (or parent of minor children) is fully responsible for any portion of their bill that is denied or otherwise not paid by their insurance carrier

09/2021

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Medical History Questionnaire

Date: _____ ***Date of Appointment:*** _____

Patient's Name: _____
Last *First* *Middle*

Address: _____ City _____ ST _____ ZIP _____

Home Phone: _____ Work Phone: _____ Mobile/Cell: _____

Date of Birth: _____ Email Address: _____

List all medications you are presently taking:

Name of Medication & Dosage	***Name of Medication & Dosage***

List any drug allergies or sensitivities:

_____ _____
_____ _____

List any previous immunizations and approximate date:

_____ _____
_____ _____

Past Medical History:

Has a doctor or other health care provider ever told you that you have any of the following?

☐ High Blood Pressure
☐ Diabetes
☐ Coronary Artery Disease (heart disease)
☐ Inflammatory bowel disease/Crohn's disease
☐ Asthma
☐ High Cholesterol
☐ Diabetes only in pregnancy
☐ Colon Cancer or polyps
☐ Breast Cancer
☐ HIV or AIDS

Are you currently receiving?

☐ radiation therapy
☐ chemotherapy
☐ oral steroid medications

Pregnancy Status: ☐ Pregnant ☐ Not Pregnant ☐ Chance of being pregnant

Date of last menstrual period? _____

List any surgeries and the year:

Surgery	***Year***

List diagnosis for any hospitalizations in past 10 years and the year hospitalized:

Diagnosis	***Year***

(If additional space is needed, please use the back of this form.)

Emotional Health:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	*Several days*	*More than half the days*	*Nearly every day*
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Social History:

Tobacco:

☐ Current Smoker ☐ Every Day ☐ Some days but not every
Per Day: ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31+
Interested in quitting? ☐ Ready to quit ☐ Thinking about it ☐ Not ready
☐ Former Smoker
☐ Never Smoked

Alcohol:

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
If yes, how often did you drink in the past year:
☐ Never ☐ Monthly or less ☐ 2-4x a month ☐ 2-3x a week ☐ 4+ times a week
If yes, how many drinks did you have on a typical day when you were drinking in the past year?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+
If yes, how often did you have 6 or more drinks on one occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Sexual History:

Have you had sex in the last 12 months (vaginal, oral or anal)? ☐ Yes ☐ No
With: ☐ Men Only ☐ Women only ☐ Both Men and Women
Use protection? ☐ Yes ☐ No

Have you ever had a Sexually Transmitted Disease? ☐ Yes ☐ No

Chlamydia?	☐ Yes	☐ No
GC?	☐ Yes	☐ No
Syphilis?	☐ Yes	☐ No
Herpes?	☐ Yes	☐ No
Other?	☐ Yes	☐ No

Asthma History:

1. Do you have coughing, wheezing, shortness of breath or tightness in the chest during the day?
☐ Twice a week or less ☐ More than half the days
☐ Several days ☐ Nearly every day

List any previous vaccinations and approximate date:

Vaccine		*Approximate Date*
Influenza	☐ Yes ☐ No	
Pneumonia/Prevnar13	☐ Yes ☐ No	
Tetanus	☐ Yes ☐ No	
Varicella (chicken pox)	☐ Yes ☐ No	
Gardasil (HPV)	☐ Yes ☐ No	
Zostavax (shingles)	☐ Yes ☐ No	

Family History:

Member	Status	DOB	Age (yrs)	Conditions
Father				
Mother				
Son(s)				
Daughter(s)				
Brother(s)				
Sister(s)				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

Do you have any specific questions for the doctor today? _____

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Patient Registration

Patient Information	
Patient Name:	
Mailing Address:	
Home Phone:	Cell Phone:
Work Phone:	Primary Care Provider:
Date of Birth:	**Social Security Number:**
Sex: M F Transgender	Email Address:
Marital Status:	Primary Language: *Translator? Y N*
Race: American Indian or Alaska Native Asian Native Hawaiian Black or African American White Hispanic Other Race Other Pacific Islander Decline to Report	
Ethnicity: Hispanic Non-Hispanic Decline to Report	

Insurance Information*	
Primary Insurance	Phone Number
Subscriber Name:	Subscriber ID:
Date of Birth:	Group Number:
Secondary Insurance:	Phone Number:
Subscriber Name:	Subscriber ID:
Date of Birth:	Group Number:

**If you are covered under another person's insurance, please notify a staff member.*

Other Information	
Employer Name:	Phone Number:
Employment Status: Full Part Self Retired Other: _____	
Emergency Contact Name:	Phone Number:
Relationship: Spouse Parent Sibling Child Other: _____	
Retail Pharmacy Name:	Pharmacy Number:
Mail Order Pharmacy:	Pharmacy Number:

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Phone: 231-935-0850 Fax: 231-935-0869

Authorization for the Use and/or Disclosure of Protected Health Information

If you are 20yrs old or younger **DO NOT** send for previous medical records. The Physician will let you know at your appointment what records are needed.

1. Please enter last provider below: (Office that will be releasing your records)

Name:

Address: City: State: Zip:

2. I authorize the following person to receive my protected health information: (Circle one)

Dr. Oakley Dr. Klettner Dr. Bultemeier Dr. Yates Dr. Hughes Mary Douglas, PA-C

3. Please only send the most recent reports below. (Do not send entire chart)

History & Physical	Laboratory Report(s)	Radiology Reports
Immunization Record	Mental Health	Operative Reports
Consult Reports	Hospital Discharge Summary	History & Physical
HIV, AIDS, or Aids-related info/testing		Drug or Alcohol Abuse

I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable diseases & infections, alcohol or drug abuse treatment and/or HIV, AIDS or AIDS-related information. **Patient must initial:**_____

4. The information will be used and disclosed for the following purposes:

Transfer of Care Insurance Attorney/Legal Other

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and submitted to the Privacy Officer at Grand Traverse Internal and Family Medicine, PC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 42 CFR Part 2

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Grand Traverse Internal and Family Medicine, PC, nor will it affect my eligibility for benefits.

Signature Date

Name (Print) Date of Birth

Name of Personal Representative Relationship to Patient

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Patient-Centered Medical Home

5015 North Royal Drive Traverse City, MI 49684
231-935-0850 www.gtinternists.com
Monday – Friday 8 am - 5 pm

The Patient-Centered Medical Home (PCMH) has become a proven method to elevate patient care by forming a healthcare team. The team at Grand Traverse Internists is committed to improving your healthcare experience and you are an integral part of your team.

As your certified Patient-Centered Medical Home we will:

- Work with your specialists to coordinate your healthcare needs
- Streamline communication with you and your specialists using some of the latesttechnology
- Provide access to an on-call doctor 24 hours a day, for serious concerns
- Offer extended office hours for acute medical needs
- Supply access to your information and communicationwith staff through the Patient Portal
- Include your goals / objectives regarding your health

As a Partner / Patient, you should:

- Take an active role in your healthcare and followthe care plan agreed upon with your doctor
- Keep your medication list current & ask for refills in a timely manner
- Understand your insurance policy; bring insurance cards and co-pays to each visit
- Keep your appointments as scheduled or call 24 hours in advance to cancel
- Use the Patient Portal when applicable
- Keep us informed about medical services received outside of GTI

To help guide your medical concerns…

After Hours –
Call 935-0850 and follow the prompts to reach our on-call physician for urgent matters.

Urgent Care – Foster Family Community Health Center -
550 Munson Ave, Traverse City 231-935-8686 8AM – 5PM Open 7 days a week

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