Welcome to Our Office!

We are honored that you have chosen us to be your healthcare provider. Please read the following information about our office. If you have any questions or concerns please don't hesitate to call.

Our Providers

Dr. Stephen Dallas, MD
Charmaine Kwei, NP-C
Pauline Rocha, NP-C

Office Contact Information

3601 S. 9th St
Kalamazoo, MI 49009
Phone: 269-383-6789
Hours: 8:30 - 4:30 Daily

PREPARING FOR YOUR FIRST OFFICE VISIT

- Please complete all the paperwork in this packet and bring it to your appointment
- Please bring your insurance cards and photo ID
- Please bring your current medications, including over the counter meds and supplements
- Co-pays are due at the time of service
- Please arrive 10-15 minutes early to complete your registration

OFFICE POLICIES

- **No Show and 24 Hour Cancellation Policy:** There will be a $25.00 charge for "no show" appointments or for patients who do not cancel their appointment 24 hours before their scheduled time. Due to the full schedule that we have, we must utilize our appointment times to their fullest potential.

- **Financial Policy:** Copays and past due balances are due at time of service. Our office will file all charges with your insurance company. Please remember you are responsible for all fees, regardless of insurance coverage.

Your new patient appointment is scheduled on _____

Signature _____ **Date** _____

Patient Demographic Sheet

Personal Information

Patient's Name:_____ Date of Birth:_____

Social Security Number:_____ Sex: M F

Address:_____ Race:_____

_____ Ethnicity:_____

_____ Preferred Language:_____

Email Address:_____

Preferred Phone:_____ Secondary Phone:_____

C W H C W H

Employer:_____Employer Phone:_____

Emergency Contact Information

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Primary Insurance Information(please bring card to all appointments)

Insurance Company:_____Member ID:_____

Group Number:_____Policy Holder:_____

Policy Holder's DOB:_____Relationship:_____

Secondary Insurance Information(please bring card to all appointments)

Insurance Company:_____Member ID:_____

Group Number:_____Policy Holder:_____

Policy Holder's DOB:_____Relationship:_____

Our office will file all charges with your insurance company. Office visits are payable on the day you are seen. Please remember that you are responsible for all fees, regardless of insurance coverage.

3601 South 9th Street
Kalamazoo, MI 49009
269.383.6789

Signature:_____Date:_____

Non-Medicare Patients (Please read and sign)

I hereby authorize Opus Medicine to furnish information to my referring physician(s) and to insurance companies concerning my illness and treatments, and I hereby assign Opus Medicine all payments for medical services rendered to myself and or my dependent(s). I understand that I am responsible for any amount not covered by insurance.

Signature:_____Date:_____

Medicare Patients (Please read and sign)

I _____ request payment of authorized Medicare benefits be made to me or on my behalf to any provider of Opus Medicine for any service furnished to me by them. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I may be responsible for any deductibles and copays.

Signature:_____Date:_____

This is a confidential record and will be kept in this office. This information will not be released to anyone without your authorization.

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Opus Appointment/No Show Policy

Thank you for trusting your medical care to Opus Internal Medicine. When you schedule an appointment with Opus, we set aside time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment, please contact our office as soon as possible and within 24 hours of your appointment. This allows us time to schedule patients who may be waiting for an appointment. Please review our no show/cancellation policy.

No show and 24 hour cancellation policy- There will be a $25.00 charge for "no show" appointments or for patients who do not cancel their appointment 24 hours before the scheduled time. Due to the full schedule we have, we must utilize our appointment time to the fullest potential.

A "no show" on the very first appointment will result in not being rescheduled with our practice.

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office within 24 hours' notice will be considered a No Show and charged a $50.00 fee. (2nd time)

If a third no show or cancellation occurs without a 24 hour notice the patient may be dismissed from Opus Internal Medicine.

Financial Policy- Copays and past due balances are due at the time of services. Our office will file all charges with you insurance company. Please remember you are responsible for all fees, regardless of insurance coverage.

If co-pays and past due balances are not paid-services for that day may be denied.

Signature_____ **Date** _____

Printed Name_____ **Date** _____

GENERAL CONSENT FOR TREATMENT

Patient Name:_____ Date of Birth:_____

Patient Acct Number:_____ Insurer:_____

General Consent for Treatment

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent.

Release of Medical Information

This form has been fully explained to me, and I understand its content and significance. I consent to Opus Medicine's use of my health information related to the medical services provided for the following purposes: my treatment, obtaining payment for the medical services and for health care operations of Opus Medicine or other treating providers, all as permitted under federal and state laws and regulations.

Payment

I assign and authorize payment, for any and all services rendered, directly to Opus Medicine from my insurance company or third party payer including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and workers disability compensation insurance.

In consideration of the health care services provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments and non-covered services.

_____

Signature of Patient Date of Signature

_____

Printed Name of Legal Representative

AUTHORIZATION FOR THE USE OF DISCLOSURE OF MEDICAL RECORDS
(PROTECTED HEALTH INFORMATION)
Form Number HF008

I,_____ hereby authorize the or disclosure of my Medical Information
(Patients Name)
(PHI), as described below.

I authorize my Medical Information (PHI) to be released/ disclosed to:

Name: Opus Internal Medicine

Address: 3601S. 9TH Street

City: Kalamazoo MI State: Zip Code: 49009

Purpose for Release/Disclosure of information:

□ Ongoing Medical Care □ At my Request □ Other: _____

Description of Medical Information (PHI) to be released/disclosed:

□ Complete Record □ Operative Reports □ Physician Notes □ Lab Reports

□ Pathology Reports □ Correspondence □ Radiology Reports □ Other: _____

This release also specifically **allows** the release of the following information **unless** the box is initialed:

_____Records of testing, care, reporting or research pertaining to HIV or related diseases

_____Drug and /or Alcohol dependency/abuse

Authorization expires one year from date of signature unless otherwise specified: Other: _____

By signing this authorization, I acknowledge that I have read and understand this Authorization and I Authorized the use/disclosure of my Medical Information (PHI) in accordance with the terms of this Authorization by Opus Medicine P.C..

I understand that I may revoke this authorization at any time, except to the extent that action has been taken on it. I further authorize that photocopy of this release may be used in place of the original.

Signature: _____ Date of Birth _____ Date _____

_____ _____
Signature of consenting party to patient Signature of Witness

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Name:_____

Signature or Patient or Representative:_____

Relationship to Patient:_____

Date:_____

I further authorize the following person(s) to make the request for the use or disclosure of my medical information (PHI) on my behalf.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

- ○ Refused to sign
- ○ Physically unable to sign

Other:_____

_____

Employee Signature:_____Date:_____

(HIPAA) MEDICAL INFORMATION RELEASE FORM

Patient Name:_____

Date of Birth:_____

Release of Information

I authorize the release of information including diagnosis and records (examination rendered to me and claims information). This information may be released to:

Name:_____

Name:_____

Name:_____

Name:_____

☐ Information is not to be released to anyone

Messages

Please call: ☐ My Home:_____

☐ My Work:_____

☐ My Cell Phone:_____

If unable to reach me: ☐ You may leave a detailed message

☐ Please leave a message asking me to return your phone call

☐ Other:_____

This release of information will remain in effect for one year from the date this form is signed or unless terminated by me in writing.

Patient Signature:_____ Date:_____

History of Past and Present Medical Conditions

Name:_____ Date of Birth:_____

Sex: **M** **F** Preferred phone:_____ Secondary Phone:_____

Address:_____ City:_____ State:_____

Emergency Contact:_____ Relationship:_____

Phone:_____

Physicians you are currently seeing:_____

_____

Hospital Preference: **Bronson** **Borgess**

Referred by:_____

Reason for coming to our practice:_____

_____

<u>Medications:</u> Please include over the counter, supplements and all prescriptions

Name of Medication Dosage

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

Allergies: Please list any foods or medications and the reaction you have

1. _____

2. _____

3. _____

4. _____

5. _____

Do you now have or have you in the past, had any of the following? Please circle yes or no and list the date you were diagnosed.

Migraine headaches	YES	NO	When: _____
Epilepsy or convulsions	YES	NO	When: _____
Stroke	YES	NO	When: _____
Glaucoma	YES	NO	When: _____
Cataracts	YES	NO	When: _____
Asthma	YES	NO	When: _____
Chronic bronchitis	YES	NO	When: _____
Tuberculosis	YES	NO	When: _____
Pneumonia	YES	NO	When: _____
Emphysema	YES	NO	When: _____
Heart attack	YES	NO	When: _____
Congestive heart failure	YES	NO	When: _____
Rheumatic fever	YES	NO	When: _____
Pacemaker	YES	NO	When: _____
High blood pressure	YES	NO	When: _____
Stomach or duodenal ulcer	YES	NO	When: _____
Vomiting blood	YES	NO	When: _____
Rectal bleeding	YES	NO	When: _____
Colon or bowel trouble	YES	NO	When: _____
Kidney problems	YES	NO	When: _____
Problems with blood clotting	YES	NO	When: _____
Phlebitis	YES	NO	When: _____
Blood clots in arteries	YES	NO	When: _____
Diabetes	YES	NO	When: _____
Gout	YES	NO	When: _____
High cholesterol	YES	NO	When: _____

High triglycerides	YES	NO	When:_____
Thyroid - overactive	YES	NO	When:_____
underactive	YES	NO	When:_____
Nervous breakdown	YES	NO	When:_____
Arthritis	YES	NO	When:_____
Cancer	YES	NO	When:_____
Blood diseases	YES	NO	When:_____

OPERATIONS: Were any of the following operated on? Circle yes or no and list date, city and hospital if known.

Tonsils	YES	NO	When:_____
Appendix	YES	NO	When:_____
Gallbladder	YES	NO	When:_____
Stomach	YES	NO	When:_____
Small intestine	YES	NO	When:_____
Kidney	YES	NO	When:_____
Colon	YES	NO	When:_____
Thyroid	YES	NO	When:_____
Hernia	YES	NO	When:_____
Varicose veins	YES	NO	When:_____
Heart	YES	NO	When:_____
Back	YES	NO	When:_____
Arteries	YES	NO	When:_____
Breast	YES	NO	When:_____
Uterus	YES	NO	When:_____
Ovaries	YES	NO	When:_____
Prostate	YES	NO	When:_____
Kidney transplant	YES	NO	When:_____
Dialysis graft	YES	NO	When:_____
Vas cath	YES	NO	When:_____

Other_____

FAMILY HISTORY: Has any blood relative ever had any of the following? Please circle yes or no.

Cancer	YES	NO	When:_____
Diabetes	YES	NO	When:_____
Heart trouble	YES	NO	When:_____
High blood pressure	YES	NO	When:_____
Stroke	YES	NO	When:_____
Bleeding disorder	YES	NO	When:_____
Varicose veins	YES	NO	When:_____
Vascular disease	YES	NO	When:_____

Other_____

PERSONAL AND SOCIAL HISTORY

Marital Status: Married Single Widowed Divorced Partner

Any children? YES NO Number of children?_____

Do you smoke? YES NO If yes, what and how much?_____

Do you drink? YES NO How much?_____

On a special diet? YES NO If yes, what kind?_____

Do you wear your seatbelt? YES NO If yes, what % of the time?_____

CIRCULATORY SYSTEM: Do you or did you experience any of the following?

Coldness	YES	NO	If yes, where?_____
Change in color	YES	NO	If yes, where?_____
Leg cramps - during day	YES	NO	How far can you walk before they occur?____
during night	YES	NO	_____
Varicose veins	YES	NO	
Ulcerations	YES	NO	If yes, where?_____

CONSTITUTIONAL

Fever	YES	NO
Chills	YES	NO
Weight loss	YES	NO

ALLERGIES

Seasonal	YES	NO
Food	YES	NO

If yes, what?_____

NEUROLOGICAL

Vision changes	YES	NO
Blurring	YES	NO
Loss of vision in an eye	YES	NO
Double vision	YES	NO
Dizziness	YES	NO
Difficulty with balance	YES	NO
Weakness (one side of body)	YES	NO
Numbness	YES	NO
Passing out spells	YES	NO
Speech difficulty	YES	NO
Memory loss	YES	NO

HEART

Shortness of breath	YES	NO
Swollen ankles	YES	NO
Chest pain with exercise	YES	NO

GENITOURINARY

Pain or blood when urinating	YES	NO
Difficulty passing urine or straining	YES	NO
Kidney failure	YES	NO

BONE S AND JOINTS

Painful joints	YES	NO
Swollen joints	YES	NO
Broken bones	YES	NO

GENITALIA - WOMEN

Breast lump	YES	NO
Nipple discharge	YES	NO

LUNGS

Coughing up blood	YES	NO
Wheezing	YES	NO
Shortness of breath	YES	NO
on exertion	YES	NO
at rest	YES	NO
Frequent cough	YES	NO

GENITALIA - MEN

Breast lump	YES	NO
Prostate trouble	YES	NO
Difficulty having erections	YES	NO
Difficulty maintaining erections	YES	NO

GASTROINTESTINAL

Poor appetite	YES	NO
Indigestion or heartburn	YES	NO
Abdominal pains	YES	NO
Diarrhea	YES	NO
Constipation	YES	NO
Recent changes in bowel habits	YES	NO
Black, tar-like stools	YES	NO

Patient's Signature/Legal Guardian:_____ Date:_____

Provider's Signature:_____ Date:_____