

Dear Patient ~ Your evaluation with _____



is scheduled on: _____, ____/____/____ @ _____

TO PREPARE FOR THIS APPOINTMENT, PLEASE BE ADVISED OF THE FOLLOWING:

- The enclosed questionnaires must be completed with permanent INK
- Please complete every page of each questionnaire as they will be included in your legal medical record...if an area does not apply to you, please fill in the blank with "N/A". The patient or legal representative must sign / date (circle designation) on every page, where indicated at bottom.
 - If time allows – please MAIL / FAX the completed forms to us prior to your appointment (additional postage may be required)... and plan to arrive 30 minutes prior to your appt time for final registration & nursing assessment

★ If time will not allow for your questionnaires to be returned prior to your appointment date, you must bring the completed forms with you to your appointment, and ARRIVE AT LEAST 45 MINUTES AHEAD OF TIME in order to allow for data entry, final registration and nursing assessment.

- Have your insurance card(s) and legal picture IDENTIFICATION** (valid Driver's license -or- state ID -or- passport) with you on day of appointment. They are **REQUIRED at EVERY visit**; they will be **SCANNED** into our system for reference, and maintained as part of your HIPAA-secure medical record.

*****IMPORTANT:** If the patient is a *minor, has a legal guardian, or is unable to "sign" for him/herself and has a Power of Attorney for that purpose, **THE DESIGNATED LEGALLY-RESPONSIBLE PERSON MUST ACCOMPANY THE PATIENT, PROVIDE VALID DOCUMENTATION AND PRESENT THEIR VALID-LEGAL PICTURE IDENTIFICATION.**

- If you are enrolled in a network insurance plan (HMO), it is your responsibility to obtain a referral for ALL visits with us, and must be available at the time of your visit(s). Please contact your primary care physician for this. Referrals may be faxed to us at 586-228-8830
- Please forward all pertinent MEDICAL RECORDS to our office prior to your visit. If we are not in receipt of information necessary for your evaluation, your appointment may be delayed or rescheduled. IF YOU HAD IMAGING on your **NECK /CHEST /ABDOMEN /PELVIS** (CT SCAN, MRI) performed *at any facility OTHER THAN McLaren Macomb*, PLEASE BRING THE ACTUAL FILMS/DISK TO YOUR APPOINTMENT.

- If you are being evaluated for a problem with your breast(s), you **MUST BRING YOUR MAMMOGRAPHY / ULTRASOUND / MRI FILMS AND REPORTS WITH YOU**...images on a disk are unacceptable as they may not allow the physician to do the appropriate comparisons.

\$\$\$ Your OFFICE VISIT CO-PAY is due at the time of your visit & will be collected when you check-in.

Please be prepared to make this payment ~ cash, check, and credit/debit cards are accepted. **IF YOU ARE UNABLE TO PAY YOUR OFFICE VISIT COPAY, YOUR APPOINTMENT WILL BE RESCHEDULED. [WE DO NOT ACCEPT BILLS LARGER THAN \$50]**

EXTREMELY IMPORTANT: YOU MUST BRING ANY AND ALL MEDICATIONS, SUPPLEMENTS, VITAMINS, HERBS, ETC – to your appointment: prescriptions, over-the-counter meds, protein drinks or other drink - anything you take – IN THEIR ORIGINAL CONTAINERS. Our nursing staff will document this information in your medical record for the physician to review.

IF YOU ARE UNABLE TO KEEP THIS APPT, PLEASE NOTIFY US AS SOON AS POSSIBLE
All appointments must be cancelled by 3 p.m. of the previous business day to avoid a \$25.00 NO-SHOW fee.

We hope that your visit with us is a pleasant and informative experience. If you have questions prior to your appointment, please call the office.
17375 Hall Road - Macomb, Michigan 48044 ~ Telephone: 586-228-0550 Fax: 586-228-8830