8338 Allen Road
Suite 101
Allen Park, MI 48101
Phone 313-386-5500 Fax 313-386-3444

Dear New Patient,

Thank you for choosing Dr. _____ of Western Wayne Physicians to be your Primary Care Physician. We would like to take a moment to welcome you to our practice.

Western Wayne Physicians provides medical care to patients of all ages. Our philosophy is to provide comprehensive medical care, while treating every patient with dignity and respect. We want to sit down and talk to patients, and provide patients with ample opportunity to discuss medical concerns with us.

We see patients for many types of medical concerns. We treat a wide spectrum of both acute illnesses and chronic conditions. Preventative care is also critical for ensuring your health, and we take that very seriously. From performing sports physicals each season, to providing cancer and osteoporosis screening, our primary focus is caring for you.

In this New Patient Package, there is paperwork that needs to be completed. There is a Medical Release of Information form, this needs to be filled out with your previous physician's information. This aids in continuing and improving the care you have already received. Our HIPAA Privacy Policy is also included, please read this and sign that you have done so. There is also a Health History Questionnaire, please fill this out to the best of your knowledge. Please mail these forms back to us, so that we can be prepared at your first appointment.

We look forward to seeing you at our new office, and we will do our best to make your visit pleasant, efficient and as complete as possible. Thank you again for giving us the opportunity to serve you and your family.

Sincerely,

Western Wayne Physicians

WESTERN WAYNE PHYSICIANS

Welcome to Our Practice

A Patient Centered Medical Home

We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice. If you have any questions, please call or visit our website: westernwaynephysicians.com

Western Wayne Physicians is a Patient Centered Medical Home

A Medical Home is a trusting partnership between a doctor led health care team and an informed patient. It includes and an agreement between the doctor and the patient that acknowledges the role of each in a total healthcare program.

We Trust You, Our Patient, To:

- Tell us what you know about your health and illness
- Tell us about your needs and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon, or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medication you are taking and ask for a refill at your office visit when you need one
- Let us know when you see other doctors and what medications they have added or changed
- Ask other doctors to send us a report about your care when you see them
- Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Respect us as individuals and partners in your care
- Keep your appointments as scheduled, or call and let us know when you cannot
- Pay your share of the visit fee when you are seen in the office
- Give us feed back so we can improve our services (We may survey you in the future to understand this better.)

As we build your medical Home you will notice some changes in the way we provide care, but many things will stay the same.

We Will Continue To:

- Respect you as an individual; we will not make judgements based on race, religion, sex, age. Disability. Etc.
- Respect your privacy; your medical information will not be shared with anyone unless you give us permission or it is required by law
- Provide care given by a team of people led by your physician, who will know you and your family
- Give the care you need when you need it
- Give care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours a day and 7 days a week
- Take care of short illnesses, long term disease and give advice to help you stay healthy
- Tell you about your health and illnesses in a way you can understand
- To improve your care we are using technology, like our Electronic Health Record and we will strive to continuously improve

Over The Next Several Months You May Notice That:

- We ask what you goal is, or what you want to do to improve your health

We ask you to help us plan your care, and to let us know fi you think you can follow the plan

- Written copies of care plans may be given in more complex illnesses
- The care team members are doing more and/or different parts of the care
- We may even remind you when tests are due so that you can receive the best quality care
- We may ask you to have blood tests done before your visit so that the doctor has the results at your visit
- We are exploring methods to care for you better; including ways to help you care for yourself

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you; we desire to continue to improve.

Emergency Care and Urgent Care

Western Wayne Physicians strives to accommodate patients who need more urgent care. Please call us to see if we can see you or guide your care. Emergency care is safer if we can communicate with the Emergency Department about your medical history and health situation.

Insurance Participation

Western Wayne Physicians participates in many health plans. Some health plans are better for preventative care than other; some health plans offer more choices. Its up to each patient to know what their insurance policy covers.

Laboratory and Test Results

We recommend you use laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. Please call is you have not heard from us a week after your tests were done.

Comprehensive Quality of Care

Please be aware, in the course of providing your care, your healthcare information may be shared among other providers involved in your care, as appropriate.

Practice Hours

Monday, Tuesday, and Thursday: 7:00 am until 7:00 pm
Wednesday, Friday: 8:00 am until 5:00 pm
Saturday: 9:00 am until Noon
Additional Office hours are available most days

Western Wayne Physicians

Robert J. Jackson M.D.
Patricia C. Nester M.D.
Jane P. Kramar M.D.
Deirdre A. Ryan P.A.-C.
Stephanie A. Rea P.A.-C.
Donna L. Angell M.D.
John T. McCracken M.D.
Daniel C. Angell D.O.
Jennifer L. Garrett P.A.-C.
Jenna M. Kleiber P.A.-C.

Fieldstone Building
8338 Allen Road, Suite 101
Allen Park, MI 48101
Telephone: (313)386-5500
Fax: (313)386-3444
Answering Service/After Hours: (800)-215-1021

WESTERN WAYNE PHYSICIANS

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

Western Wayne Physicians is required to maintain the privacy of your health information and how we may use and disclose your health information.

Western Wayne Physicians may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

We may contact you to provide appointment reminders, information about treatment, or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, unless the authorized request has been processed.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the office manager.

The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction.
The right to inspect and or receive a copy of your protected health information.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information, for purposes other than treatment, payment or operation.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003. We reserve the right to change the terms of our notice of privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you are concerned that your Protected Health Information has been violated, you have the right to file a written complaint with our office manager or with the department of Health & Human Services; Western Wayne Physicians will not retaliate against you for filing a complaint.

Send all complaints or questions regarding this policy to:

Western Wayne Physicians

ATTN: Office Manager

8338 Allen Road Suite 101

Allen Park, MI 48101

Tel: (313) 386-5500

WESTERN WAYNE PHYSICIANS

Addendum to Notice of Privacy Practices
September 23, 2013

Effective September 23, 2013 there have been some changes to the Health Insurance Portability and Accountability Act (HIPAA), below are the changes.

1. **Breach Notification**: In case of a breach, we will notify all patients if your Personal Health Information (PHI) has been involved.
2. **Disclosures to health plans**: You have the option to pay out f pocket for any services performed in our office and elect to have this service billed to your insurance company. We will therefore not disclose this information to your insurance company per your authorization unless required by law.
3. **Marketing Communications**: Western Wayne Physicians does not distribute marketing communications to receive compensation without the patient's written consent. We may provide communication regarding your medications and/or testing being ordered in which we do not receive compensation.
4. **Sale of PHI**: Western Wayne Physicians does not sell any patients PHI

Western Wayne Physicians

8338 Allen Road

Suite 101

Allen Park, MI 48101

I am a **NEW** patient at Western Wayne Physicians, PLC.

I have received from the office a copy of the **Notice of Privacy Practices and the new Sept. 2013 Addendum to the Notice of Privacy Practices**. I understand that by signing this I am not agreeing to anything. This is only an acknowledgement of receiving a copy of this notification.

Patient Name: _____

DOB: _____

Patient/Guardian Signature: _____

Date: _____

WESTERN WAYNE PHYSICIANS FINANCIAL POLICY

Thank you for choosing Western Wayne Family Physicians as your medical care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed a payment policy.

Due to constant changes in insurance, it is no longer possible for us to interpret each individual's policy. Although we try to stay aware of the changes, it is not possible. It is your responsibility to know your individual coverage. Please do not get angry at us if your insurance does not cover our services. All insurance policies have exclusions and most policies have deductibles and co-payments which can change yearly. Please remember that your insurance policy is between you and your insurance company and NOT between the insurance company and the doctor. We will not become involved in a dispute between you and your insurance company regarding deductibles, co-payments, secondary insurance, usual and customary charges etc., other than to supply factual information as necessary. You are responsible for timely payment of your account. Coverage limitations are dependent on coverage; please contact your insurance carrier directly. If a balance remains after 60 days, we retain the right to recover this amount as soon as possible.

CO-PAYMENTS AND DEDUCTIBLES: All copayments must be paid at the time of service, unless you have a secondary insurance carrier or other arrangements have been made prior to your appointment. The amount we collect is solely determined by what your insurance company tells us with regard to benefits and deductible information. Please help us by paying your co-payment at each visit. If you are without insurance (self-pay), and or the amount owed is large or represents a financial burden, please contact the billing office (313) 386-3408 Monday-Friday 8:30am to 4:30pm.

NON-COVERED SERVICES: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance company. The fact that the insurance company does not cover the service does not mean that you do not need it. Your doctor will explain why he or she thinks that you can benefit from a service or procedure. If you elect to have the non-covered service, you must pay at the time of visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Western Wayne Physicians Financial Policy

COVERAGE CHANGES: If you insurance coverage changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We no longer have family/joint accounts, so please remember all accounts are separate. It is the responsibility of the patient/guarantor to provide *accurate and timely* insurance information. Inaccurate or untimely insurance information given to the

staff results in denial or non coverage by your insurance company can result in the patient/guarantor being responsible for payment.

MISSED APPOINTMENTS: We reserve the right to charge for missed appointments for those that are not cancelled within 24 hours of the date of the appointment. This is not payable by insurance, and must be paid by you prior to your next appointment. Our fee is $60.00 for new or return visits. These charges will be your responsibility and will be billed directly to you. Please help us to serve your better by keeping your regularly scheduled appointment or cancelling with us at least 24 hours in advance.

ACCEPTABLE FORMS OF PAYMENT: We accept cash, check, money order, Visa, MasterCard, Discover, and American Express. If your check is returned a fee of $25.00 will be assessed for each personal check returned by your bank.

If you are having problems paying your bill, please contact the billing office at (313)386-3408 to set up a payment plan.

I have read and understand the **Office Financial Policy** and agree and to comply and accept the responsibility for any payment(s) that become due as outlined previously.

Patient Name: _____ Date: _____

Patient/Guarantor Signature:_____

WESTERN WAYNE PHYSICIANS

Dr. Donna Angell M.D. Dr. Jane Kramar M.D.
Dr. Robert Jackson M.D. Deirdre Ryan P.A.-C.
Dr. Patricia Nester M.D Jennifer Garrett P.A.-C.
Dr. John McCracken M.D. Stephanie Rea P.A.-C
Dr. Daniel Angell D.O. Jenna Kleiber P,A.-C..

8338 Allen Road Suite 101 Allen Park, MI 48101
Phone: (313)386-5500 Fax: (313)386-3444

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____D.O.B. _____

SSN (last four digits) _____

I request and authorize _____

(Name of Physician/Facility releasing information)

To release information contained in my records, including, as applicable: information about communicable disease and infections, as defined by statute and Michigan Department of Public Health rules, (which include venereal disease, TB, HIV and AIDS, Alcohol and drug abuse treatment information protected under regulations in 42 Code of Federal Regulations Part 2. Psychological services and social services information including communications made by me to a social worker or psychologist, to be sent to the individual indicated below:

Western Wayne Physicians

8338 Allen Road Suite 101

Allen Park, MI 48101

Attention: (please circle one)

Donna Angell M.D Robert Jackson M.D. Patricia Nester M.D.
John T. McCracken M.D. Jane Kramar M.D. Deirdre Ryan P.A.-C.
Jennifer Garett P.A.-C Stephanie Rea P.A.-C. Jenna Kleiber P.A.-C.
Daniel Angell D.O.

This request and authorization applies to:
Medical Records from:

- ☐ Oakwood (Beaumont) Hospital
- ☐ Henry Ford Wyandotte Hospital
- ☐ Colonoscopy and/or EGD
- ☐ Pathology Reports
- ☐ Major surgical Summaries
- ☐ Last 3 years radiology reports
- ☐ Chronic problem Lists
- ☐ Allergies
- ☐ Immunizations
- ☐ Other: _____
- ☐ Other:_____

- I ACKNOWLEDGE that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed by them and no longer protected by the Privacy regulations.
- I ACKNOWLEDGE that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.
- I ACKNOWLEDGE that I may revoke this Authorization in writing at any time by contacting the disclosing party (WWP or other entity) except to the extent that action has been taken in reliance on this Authorization. This authorization expires 6 months from the date signed.

Patient/Guardian Signature: _____ Date:_____

Registration Form

Name: _____ **Date of Birth**: _____

Social Security Number: _____ (at least the last four digits)

Home Address: _____

(Number and street name)

_____ _____ _____

(City) (State) (Zip Code)

Phone number: _____ _____

(Primary Number) (Secondary Number)

E-mail address: _____

* By providing your e-mail address you can have access to our web-based patient portal. This portal allows you to view all your test results and visit information on-line. This option is strongly encouraged for all our patients. Your e-mail address will never be solicited by any other company.

Marital status (please circle one): Single Married Widowed Divorced

Emergency contact (please list Name and Phone Number other than same number listed above):

_____

If **Minor** please list Name and address of person Responsible for patient:

_____

Name of Insurance	ID number and Group Number	Subscriber (carrier of insurance)

I hereby authorize Dr. _____ to release any and all medical information to the above named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him/her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree, in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

Insured/Guardian's Signature _____ Patient's Signature _____

Race (please circle one choice):

Asian American Indian African American Caucasian Prefer not to disclose

Ethnicity (please circle one): Hispanic Non-Hispanic Prefer not to disclose