PATIENT-CENTERED MEDICAL HOME-NEIGHBOR

Comprehensive and Integrated Health Care

Our patient centered medical home neighbor is health care focused on you, the patient. It is a partnership between you, your primary care provider and us. As your specialty provider we work within your healthcare team to provide all of your health care needs.

As part of your healthcare team we are partnering with your primary care provider (PCP) and coordinating your care. We are sharing their commitment to effectively and efficiently co-manage your care over time. As your specialist we will be sharing limited or long-term management of your condition with your PCP. We will provide advice, guidance, and periodic follow up until your illness has stabilized or treatment has been completed.

The Goals of a Patient Centered Medical Home (PCMH-N) include:

- A discussion with your provider regarding your health care goals.
- Asking for your input in planning your care and designing a plan which you can follow.
- Exploring methods to appropriately care for you, and ways to help you care for yourself.
- A reminder when appointments or tests are due so that you may receive the highest quality of care.
- Provide access to medical care 24 hours a day, 7 days a week.\

The PCMH-N concept includes an agreement between the specialist provider and the patient that acknowledges the role of each in a total health program. We will always respect you as an individual without discrimination, including your privacy and confidentiality. We will remain committed to providing the highest quality of care and professionalism.

Care Coordination

If you are hospitalized, following up with your PCP is essential to your recovery and minimizes possible complications. You should schedule an appointment with you PCP within 7 days after discharge. Care Management Services are available to assist you with transportation needs, education, or other concerns. For more information or to access services; please contact our care coordinators at (844) 368-1817.

Emergencies

Regardless of the time of day or night, if medical attention is needed please contact your PCP office for medical advice, emergency care, and/or guidance to our preferred after-hours care facility. Call 911 or go directly to the nearest emergency room if you are having any of the following:

- Chest pain
- Extreme shortness of breath
- Head injury or trauma
- Seizures
- Pregnancy complications
- Signs of a stroke (numbness, paralysis, slurred speech)
- Poisoning
- Complicated fracture
- Heavy bleeding that does not stop in 10 minutes
- Severe burns
- Homicidal feelings
- Suicidal feelings

Patient-Centered Medical Home-Neighbor

As our patient, we encourage you to:

- Call your primary care provider FIRST with all medical problems, unless it is a medical emergency.
- Ask questions, share feelings, and be part of the care process.
- Be honest about your medical history, symptoms, and other health information.
- Tell your provider about any changes in your health and well-being.
- Take all your prescribed medications and follow your provider's advice.
- Make healthy decisions about your daily habits and lifestyle, for example, healthy eating.
- Prepare for and keep scheduled visits or reschedule visits in advance.
- Create goals for your health.

Staff and providers in this office agree to:

- Communicate with your PCP regarding your care.
- Explain disease, treatments and results in words you can understand.
- Listen to your feelings and questions to aid in informed decision making.
- Keep treatments, discussions, and records private.
- Provide 24-hour access to medical care provider.
- Offer same day appointments when possible.
- Provide clear instructions for your health care needs when the office is not open.
- Care for you through evidence-based medicine and best practice recommendations.
- Provide timely follow-up after hospital stays.
- Notify your PCP of any additional referrals.
- Notify your CP of any canceled or no-show appointments.

Test results

We may ask that tests be performed prior to your visit. All patients will be notified by mail and/or phone within 48 hours after the ordering provider reviews test results. Notification will be in the form of an office visit, mail, or phone call. Test results will be shared with your PCP within 7-10 days of our review and notification.

To schedule an appointment, please call:

Cosmetic Dermatology and Vein Centers- (248) 690-7243

Tuesday: 6 a.m. – 4 p.m.

Thursday: 6 a.m. – 12 p.m.

Insurance

We participate in many health plans. Some plans offer more choices. We encourage you to become familiar with your health plan coverage.

Our Providers

Dr. Scott Friedman, DO

Patient-Centered Medical Home-Neighborhood

Patient – Provider Agreement

I have received the Patient-Centered Medical Home-Neighborhood brochure describing this model of care, what I can expect from my physician, and what is expected of me. My physician has also discussed the details of patient Centered Medical Home Neighborhood with me and has answered any of my questions.

_____	_____
Patient Print Name	**Date of Birth**
_____	_____
Patient (Guardian) Signature	**Date**
_____	_____
Physician Signature	**Date**

Cosmetic Dermatology and Vein Centers

Are you in need of community resources?

Sometimes, people have things going on in their lives that make it hard to stay well. We can put you in touch with people who may be able to assist you. Please answer each question below. When you are done, please return this form to our staff.

It's hard for me to cook, clean or take care of my house.	A lot Sometimes Not at all
It's hard for me to get dressed or take a shower or bath.	A lot Sometimes Not at all
I have trouble reading written instructions.	A lot Sometimes Not at all
I don't always take my medicine or I cut pills in half to save money.	A lot Sometimes Not at all
I have trouble paying my medical bills.	A lot Sometimes Not at all
I worry that, in the near future, I may not have a place to live.	A lot Sometimes Not at all
I do not feel safe where I live.	A lot Sometimes Not at all
I sometimes run out of food or worry about how I will feed my family.	A lot Sometimes Not at all
I worry about getting my children clothing, food, diapers, or other needs.	A lot Sometimes Not at all
People tell me that I drink/use drugs/smoke cigarettes too much.	A lot Sometimes Not at all
I feel sad or worried about what is going on in my life.	A lot Sometimes Not at all
I miss school or work because I do not have anyone to watch my children, sibling, or elderly parent(s).	A lot Sometimes Not at all
I miss school, work, or doctor appointments because I cannot get a ride.	A lot Sometimes Not at all
I recently had my utilities shut off.	Yes No
Would you like assistance with any of these needs?	Yes No

Last Name: _____ First Name: _____

Date of Birth: _____ Contact Number: _____

Preferred Language: _____ Best Time to Contact: _____

Office Use Only:

Date of Office Visit: _____

Referral Form Given: _____

Medical History

Patient Name: _____ Male / Female Married / Single Age: _____

Reason for today's visit: _____

How long has condition been present: _____

Have you been treated for this before? ( ) Yes ( ) No When (approximately)? _____

Are you allergic to any medications? ( ) Yes ( ) No If yes, please list: _____

_____

List all medications you are currently taking including birth control, vitamins, and social drugs:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you now, or have you ever had diseases or conditions related to: (please check all that apply)

Allergies, environmental		Stomach pain, dark stool		Hormonal / irregular menstrual cycles		
Allergies, medication		Painful or frequent urination		Skin lesions or rash		
Allergies, tape-adhesives		Bruising or painful lumps		Immunologic / blood disorders		
Weight loss, fatigue, fevers		Weakness or headaches		Cancers		
Eye problems, visual changes		Depression or anxiety		Poor healing (scarring / long healing)		
Problems hearing, sore throat		Bone or joint pain, muscle aches		Surgery		
Breathing problems, cough		Diabetes		Do you drink alcohol?	Y	N
Chest pain, palpitations		thyroid		Do you smoke?	Y	N

An unchecked box indicates that you do not; nor have ever had a disease or condition related to the above.

Personal history of Melanoma or other skin condition: ( ) Yes ( ) No

IF YES TO ANY ABOVE, PLEASE EXPLAIN: _____

_____

_____

Occupation: _____

Do you have a history of multiple sunburns or significant sun exposure associated with work/recreation? ( ) Yes ( ) No

When you are exposed to the sun, do you: ( ) Tan only ( ) Tan and burn ( ) Burn

Have you ever had dental anesthesia (Novocaine)? ( ) Yes ( ) No Any bad reaction? ( ) Yes ( ) No

List any other disease or condition we should know about: _____

(Women) Are you pregnant, breast feeding, or considering having children within the next year? ( ) Yes ( ) No

FAMILY HISTORY (IF YES, PLEASE GIVE RELATIONSHIP)

Any family history of Melanoma? ( ) Yes ( ) No Other types of skin cancers? ( ) Yes ( ) No

If yes, please explain: _____

Other types of cancer? ( ) Yes ( ) No Other conditions or skin diseases? ( ) Yes ( ) No

If yes, please explain: _____

_____

Patient / Gaurdian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Patient Information

_____ _____ _____ _____
Last Name First Name Middle Initial Marital Status

_____/ _____/ _____ _____ _____/ _____/ _____ Please Circle: Male Female
Date of Birth Age Social Security Number

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Cell Phone Home Phone Email Address

Preferred method of contact (circle all that apply): Cell Home Text Email

Best time to contact: AM PM

I give permission for Dr. Friedman's office to leave detailed messages (voice or text) that may include test results

(Circle preference): Cell Phone Home Phone Patient/Guardian Initials: _____

_____ _____ _____
Emergency Contact Relationship Phone Number

I give permission to the following to have unlimited access to my medical records, appointment information, and billing information at Dr. Friedman's office. I understand that at any time, I may remove the names from this list. This agreement is valid for a period of one year from the date of signature.

Name Relationship Phone Number

_____ _____ _____

_____ _____ _____

Please note that we are required by federal mandate to ask the following questions. We apologize to any patient that is offended by the questions below. Please circle or specify your responses:

Decline to answer

Race: African American Asian Caucasian Other _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other _____

Preferred Language: English Spanish Other _____

PRIVACY NOTICE ACKNOWLEDGEMENT

I have received a copy of Cosmetic Dermatology & Vein Center's Notice of Privacy Practices

_____ _____
Patient / Guardian Signature Date

COSMETIC DERMATOLOGY & VEIN CENTERS

Scott Friedman, D.O.

INSURANCE VERIFICATION FORM

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ALL OTHER INSURANCE

Patient's or Authorized Person's Signature:

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits either to myself or the physician who accepts the assignment.

_____ _____

Signature of the Insured or Authorized Person Date

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MEDICARE AND SUPPLEMENT INSURANCE

This form is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that they payer requires for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me, to release the Social Security Administration and health Care Financing Administration (or its intermediaries or carriers) any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits only apply.

_____ _____

Signature as it appears on Medicare Card Date

****

If you have a supplement policy and it is a Medigap policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap carrier any information needed to determine these benefits for the benefits payable for related services.

_____ _____

Signature as it appears on Medicare Card Date

Cosmetic Dermatology & Vein Centers Financial Policy

Thank you for choosing Cosmetic Dermatology & Vein Centers as your skin care provider. We are committed to your care and the success of your treatment. The following is our financial policy. If you have not been seen by a physician in our offices in the past 3 years, you are considered a new patient and will be billed accordingly. Please read our financial policy carefully and sign prior to your treatment.

Please note that due to HIPAA (Health Insurance Portability and Accountability Act) and other federal regulations, we required that you review our financial policy prior to signing it.

Patient or Guardian Initials: _____ Date: _____

Insurance

It is our policy, and insurance regulates, there may be separate charges for each condition that is treated. Dr. Friedman participates in most insurance plans and we will submit claims to your insurance carrier for covered medical services. Dr. Friedman accepts what your insurance allows as payment in full. This means that you are only responsible for non-covered services, deductibles, and/or co-payments. If your policy has a co-pay for services or if you are in doubt as to whether your treatment is a covered benefit, please inquire prior you you receiving treatment and incurring any charges. Due to the rapid changes in insurance company policy and privacy regulations, it is not always possible for us to accurately obtain or confirm your benefits, deductibles, or co-pays. It is ultimately your responsibility to be aware of your contract benefits. It is not our policy to routinely quote prices, however, if it is of concern, the staff will be happy to answer any billing questions you may have.

Patient or Guardian Initials: _____ Date: _____

Cosmetic Procedures

Fees for cosmetic procedures are quoted at your consultation with our staff. Your insurance carrier does not cover fees for cosmetic services and payment is required prior to services rendered.

Minor Patients

A minor patient is required to be accompanied by a parent or legal guardian for treatment. If your minor child continues care and we are unable to accommodate your schedule, please consult with a staff member to make arrangements for us to treat your minor child.

Payment

We accept cash, personal checks, Care Credit, and MasterCard or Visa for payment. To avoid any disappointment or misunderstanding, if you are concerned about your charges for treatment, please inquire prior to receiving treatment and incurring charges. **Co-pays are due in full on the date of service.**

A 1.5% per month late fee will apply on the amount of any account 30 days overdue. There is a $25.00 fee charged for any returned check (this amount may vary depending on what our bank charges us for your returned check). We reserve the right to charge for missed appointments and associated costs.

I have read and understand the above Financial Policy. I accept and agree to the terms outlined herein and agree to the treatment by Dr. Friedman and/or his assistants. The policy shall remain in effect until revoked in writing by the undersigned responsible party.

Patient or Guardian Initials: _____ Date: _____