GANDHI NEUROLOGY & SLEEP CLINIC

2025 Ford Ave., Wyandotte, MI 48192
Phone: (734) 281-3080
Fax: (734) 281-8815

NOTICE
As of June 1, 2015

If an appointment is not cancelled at least 24 hours in advance you will be charged a $30.00 fee. This fee will be the responsibility of the patient and will not be covered by your insurance company.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

YOUR COPAY IS DUE AT THE TIME OF SERVICE, UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

Thank you for choosing our office for your health care needs. You are receiving this letter to inform you of your insurance and financial responsibility. It is best for you to know what your health insurance plan will pay for and what you may have to pay. Please contact your health insurance plan for more information by calling the phone number on your health insurance card.

- **Keep up with your health insurance plan** - It is your responsibility to make sure your health care plan is active before scheduling an appointment. It is also your responsibility to let the staff know about any changes to your health insurance plan *PRIOR* to your appointment.
- **Get care from an approved provider** - It is your responsibility to check with your health insurance plan and make sure our provider is in your network.
- **Referrals** - It is your responsibility to get any referrals needed *PRIOR* to your appointment.
- **Know what you have to pay** – You must pay your copay upon checking in *PRIOR* to seeing the doctor. The patient will receive a bill with any unpaid amount that must be paid by the due date stated on the bill.
- **Debt collection** – Any unpaid balance must be paid by the date on the billing statement, or the bill will be turned over to a debt collector. You may schedule a payment plan with the office biller to make payments until the debt is paid in full.
- **Thank you in advance for your cooperation** ☺ **Revised 3-9-2021**

-----PLEASE READ-----

Welcome To Our Specialty Practice

We are a part of your Patient-Centered Medical Home Neighborhood!

We are partnering eith your Primary Care Physician as they build your Medical Home. We are sharing their commitment to effectively and efficientyly co-manage your care over-time. As your Specialist, we will be sharing limited or long term management (depending on the nature of impact) of your condition and provide advice, guidance and periodic follow-up until the crisis or treatment has been stabilized or complete.

You may notice that:

We will be communicating with your Primary Care Physician (PCP) and will be providing timely written reports on our consultation with you to them.

We will be notifying your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.

We will be providing future scheduled appointments and treatment palns.

We will be notifying PCP of referrals needed for other Specialties.

We trust you, our patient, to:

Keep your appointment as scheduled, or call and let us know when you cannot.

Learn about your insurance, so you know what it covers.

Learn about wellness and how to prevent diseases.

Seek the advice of your PCP before you see other physicians.

Follow the care plan that is agreedupon-or let us know why you cannot so that we can try to help, or change the plan.

Tell us what medications you are taking and ask for a refill at your office visit when you need one.

See your PCP on an annual bases for all preventive services.

We will continue to:

Remind you when tests are due so that you can receive the best quality care.

Ask you to have blood tests done before your visit so that the doctor has the results at your visit.

PRACTICE HOURS
MONDAY - FRIDAY
9 AM - 5 PM

EEG TESTING
MONDAY AND FRIDAY
9 AM - 12 NOON

MONDAY- THURSDAY
3 PM AND 4 PM

EMG TESTING
MONDAY AND FRIDAY
1 PM, 2 PM,AND 3 PM

TUESDAY- THURSDAY
12:30 PM, 1:15 PM, AND 2 PM

A Patient-Centered Medical Home (PCMH) is a system of care in which a team of health professionals' work together to provide all of your health care needs. You, the patient, are the most important part of a patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that they're getting the care you need.

AFTER HOURS CARE

IF YOU HAVE HEALTH CARE NEEDS AFTER-HOURS, PLEASE CONTACT YOUR PRIMARY CARE/FAMILY PHYSICIAN .
IF ADDITIONAL COORDINATION IS NECESSARY, YOUR PCP WILL CONTACT DR. GANDHI.

TEST RESULTS

PLEASE TRY TO USE LABORATORIES AND OTHER TEST FACILITIES WE USE REGULARLY TO ENSURE BETTER COMMUNICATION. WE STRIVE TO GET TEST RESULTS TO PATIENTS. IF YOU HAVE NOT RECEIVED A CALL OR NOTIFICATION BY MAIL WITHIN 14 DAYS AND/OR DO NOT HAVE A FOLLOW-UP APPOINTMENT, PLEASE CALL THE OFFICE FOR YOUR RESULTS.

AVAILABLE COMMUNITY SERVICES

NEED HELP? 2-1-1 NOW AVAILABLE IN WAYNE COUNTY! DIAL 211 FROM ANY PHONE AND YOU WILL BE CONNECTED WITH A REFERRAL HOTLINE THAT CAN CONNECT YOU WITH NON-PROFIT AGENCIES IN THE AREA THAT CAN HELP WITH HUMAN, HEALTH AND SOCIAL, NEEDS (I.E., UTILITIES, HOUSING, HEALTH INSURANCE, FOOD, DIAPERS, ETC.)

A LISTING OF THE AREA RESOURCES CAN ALSO BE FOUND ON THIS WEBSITE: http://www.referweb.net/uwic/
or
PLEASE ASK OUR STAFF FOR INFORMATION PERTAINING TO YOUR SPECIFIC NEEDS.

PATIENT WEB-PORTAL

WE HAVE A PATIENT PORTAL THAT SUPPORTS TWO-WAY, SECURE A COMPLIANT COMMUNICATION. IF YOU WOULD LIKE TO ACCESS YOUR MEDICAL INFORMATION PLEASE ASK US HOW TO DO SO.

Ravinder Gandhi MD PC
Balbir Gandhi MD
Nitin Gandhi DO
2025 Ford Ave
Wyandotte, MI 48192
734-281-3080

PATIENT FINANCIAL RESPONSIBILITY

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- **Thank you in advance for your cooperation** 😊

Revised 10 / 2018

HIPAA PRIVACY NOTICE

At this facility, we respect the privacy and confidentiality of your health information. This Privacy Notice describes how we may use and disclose your medical/health information. This Notice applies to uses and disclosures we may make of your health information whether created or received by us. By law, we are required to maintain the privacy of your health information and provide you with notice of our legal duties and privacy practices.

Right to Notice

Under the Health Insurance Portability and Accessibility Act (HIPAA), Michigan physicians can use your protected health information for treatment, payment, and health care operations. A) Treatment – we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. B) Payment – we may use or disclose your health information to obtain payment for services we provide to you. C) Healthcare Operations – we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement with your healthcare.

Marketing

We will not use your health information for marketing communication without your written authorization.

Required by Law

We may also use or disclose your health information when we are required to do so by law. We may disclose information in response to a subpoena, discovery request or other lawful process.

Risk to Public Health

We may disclose your health information when required by law to prevent, control, or report disease, injury or disability. To collect or report adverse events and product defects, track Food and Drug Administration (FDA) regulated products; enable product recalls, repairs or replacements and review.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates of patients to the appropriate authorities under certain circumstances.

For Organ Donation or to Coroners or Funeral Directors

We may disclose your health information such as for organ, eye or tissue donations; identification purposes; performing other duties by law.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail, text message or letter.

Your Rights as a Patient

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or healthcare operations. You have the right to receive confidential communications regarding your protected health information. You have the right to receive an account of disclosure of your protected health information. You have the right to paper copy of this notice of privacy practices.

REGISTRATION FORM

This form MUST be filled out completely and signed.

Patient Information:

Name: _____ SSN: _____ Gender: M / F

Address: _____ City: _____ Zipcode: _____

Birthdate: ____-____-____ Marital Status: S M D W Phone # _____-_____-_____

Emergency Contact: _____ Phone #: _____-_____-_____

Relationship to Patient: _____

Primary Insurance: _____

Secondary Insurance: _____

Primary Care Doctor: _____

Is this an auto accident case or workers comp visit? YES / NO

Insurance name _____ Phone number _____

Adjuster name _____ Case # _____

Date of injury ____-____-____ Part of body injured _____

Assignment and Release:

I certify that I have insurance coverage and understand assign directly to Dr. Gandhi all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Please list any individual (family member, friend) that takes part in your medical care. Dr. Gandhi and his staff have permission to discuss your medical condition and possible treatment plan with said persons. If no one is listed below, we will only be able to discuss your care with you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

HIPAA Notice and Acknowledgement

I acknowledge that I have received the Notice of Privacy Practice and all above information is correct.

Patient's Signature: _____ **Date:** _____

This form will remain in power until revoked in writing by patient.

Revised 12 / 2022

HEALTH HISTORY

Name: _____ Date: ____-____-____

Pharmacy: _____ Pharmacy City: _____ Cross Section: _____

Reason for visit: _____

Past Medical History and Family History

	Patient	Mother	Father	Siblings
Cancer				
Dementia				
Diabetes				
High blood pressure				
High cholestrol				
Migraine				
Seizure				
Sleep Apnea				
Snoring				
Stroke				

Other: _____

Social History

Do you use:	Yes	How much?
Caffeine		
Tobacco		
Alcohol		
Recreational Drugs		
Other: _____		

If other please specify:

_____

Surgical History:

Please list all surgeries and the year it was performed.

_____

_____

_____

_____

_____

PLEASE BRING IN A LIST OF YOUR ALLERGIES AND MEDICATIONS

(If you don't have a list with you our staff will go over the medication list currently in our system)

Medication List Example

Name	Strength		How often?
Asprin	81 mg		daily