Join us in building our

Patient Centered Medical Home

A Patient Centered Medical Home is not an actual building.

It is a home base for your healthcare needs and a partnership between you, your doctor and other office team members. The care you receive here is centered on you. Together, we will work towards making you as healthy as possible.

We will provide you with the information needed to help maintain or improve your health. However, you must be willing to apply these tools to your lifestyle. Your visit with your doctor is always kept private. Therefore, the more honest you are in answering the questions asked, the better the doctor can diagnose and treat you.

You will be receiving a document today called a Patient-Provider Partnership Agreement, which explains this team approach and our mutual goals.

Your health is very important to us and we will try to answer all of your questions and concerns.

We look forward to further working with you in your health care needs.

Associated Psychologists
David Lujan, D.O.
Cheryl Mazzara, M.D.
Desanka Stipic, M.D.

Patient-Provider Partnership
Specialists Agreement

The health and wellness of our patients is our top priority. Our primary goal is to provide the best possible care to every patient. Your treatment will be coordinated with your Primary Care Physician. Below are some guidelines to make the best of this partnership.

As our patient, your responsibilities are to:

- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Participate and commit to the treatment plan that has been developed for you.
- Be sure you understand the treatment plan. If not, ask questions.
- Tell us immediately if you are unable to follow your recommended treatment plan, so we can modify it for you to receive the best results possible.
- Be honest about your history, symptoms and other important information that pertains to your health.
- Tell your healthcare team about any changes in your health and/or well-being.
- Follow up with your Primary Care Provider for overall healthcare needs.

As your provider office, our responsibilities are to:

- Schedule your appointment as soon as possible.
- Communicate regularly with your Primary Care Provider to coordinate your care.
- Develop a treatment plan based on your needs.
- Assist you with establishing goals and provide you with information to help you learn how to self-manage your condition.
- Direct and coordinate your care through referrals to appropriate community resources when necessary.
- End every visit with clear instructions about your diagnosis, expectations, treatment goals and future plans.

If you are having a psychiatric emergency,

please call 9-1-1 or go to the nearest Emergency Room.

National Suicide Prevention Hotline:

(800) 273-8255

Harbor Oaks Hospital
35031 23 Mile Road
New Baltimore, MI 48047
(844) 359-5285
harboroaks.com

Havenwyck Hospital
1525 University Drive
Auburn Hills, MI 48326
(800) 401-2727
havensyckhospital.com

Henry Ford Cottage
131 Kercheval Ave., Lower Level
Grosse Pointe Farms, MI 48236
(313) 640-2637
henryfordcottage.com

Macomb County CMH Services
22550 Hall Road
Clinton Township, MI 48036
Voice: (586) 469-5275
24-Hour Crisis: (586) 307-9100
TDD/TYY: (586) 307-9100

Oakland County CMH Authority
2011 Executive Hills Boulevard
Auburn Hills, MI 48326
Voice: (248) 858-1210
24-Hour Crisis: (800) 231-1127

Wayne County CMH Agency
640 Temple, 8th Floor
Detroit, MI 48201-2555
Voice: (313) 833-2500
24-Hour Crisis: (800) 241-4949
TDD/TYY: (800) 630-1044

NEW OAKLAND FAMILY MENTAL HEALTH

CRISIS LINE: (800) 395-3223

Centerline: (586) 759-4400

Clinton Township: (586) 412-5321

Farmington Hills: (248) 855-1540

Livonia: (734) 422-9340

Clarkston: (248) 620-6400

ASSOCIATED PSYCHOLOGISTS
DAVID LUJAN, D.O.
CHERYL MAZZARA, M.D.
DESANKA STIPIC, M.D.

Date: _____ Patient name: _____

1: I understand that it is my responsibility to know my insurance benefits.

2: I understand that it is my responsibility to pay all deductibles and copayments at the time of service, per your individual insurance benefits.

3: I understand that it is my responsibility to inform the office, prior to my appointment, of any insurance changes. Otherwise, I may be responsible for services rendered.

4: I understand that it is my responsibility to inform the office of any phone and/or address changes.

_____ _____

Patient/Parent Guardian Witness

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

_____ attempted to obtain patient's acknowledgement but was unable to do so. The reason it was not obtained was _____.

Signature _____

Date _____