Ganesh Deshmukh, M.D. FACS, FASCRS
Adewunmi Adeyemo, M.D. FACS
Vishnu Pemmaraju, MD
3106 S Wayne Rd., Wayne, MI 48184
3535 W 13 Mile Rd., Suite 236, Royal Oak, MI 48073
19135 Allen Rd, Suite 106 Brownstown, MI 48183
Phone: (734)722-6300 Fax: (734)722-4815
Email: micrs3106@gmail.com
Website: www.grdoffice.com

To Whom it May Concern:

Please complete all paperwork in **BLACK or BLUE** ink. You can mail, fax, or email completed paperwork along with a **copy of your DRIVERS LICENSE/ID and INSURANCE CARD(S).** Please include a copy of the front AND back of the insurance card(s).

Once all completed paperwork is received, we will call you to schedule your procedure. If we **DO NOT** receive **ALL** of the requested information, it will delay your process of being scheduled.

Please **DO NOT** mail back or throw away the Prep Instruction Sheet! You will need the instructions to prepare for a colonoscopy.

Please keep the Office Policies for your records.

It is your responsibility to know your insurance benefits.

Thank you,
Dr. Deshmukh, Dr. Adeyemo's & Dr. Pemmaraju's office staff

To submit completed paperwork:

MAIL to 3106 S Wayne Rd., Wayne, MI 48184
If you want to drop the paperwork off, please call the office to make sure someone is here in the office.

Or
EMAIL to micrs3106@gmail.com

Or

FAX to (734)722-4815

Ganesh Deshmukh, M.D Adewunmi Adeyemo, M.D Vishnu Pemmaraju, M.D.
3106S Wayne Rd., Wayne MI 48183
734-722-6300 Fax 734-722-4815

Date: _____

Location: _____

****It is very important that you follow these instructions when prepping for you colonoscopy/surgery or your procedure may be rescheduled. ****

It is very important that any and all blood thinners such as Aspirin, Aspirin containing products, Plavix are stopped 7 days prior, Coumadin and Warfarin are stopped 3-5 days prior and Eliquis, Savaysa, Xarelto and Pradaxa are stopped 3 days prior to your colonoscopy/surgery. Please check with the physician who prescribed these medications before stopping. If you take Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Rybelsus, Saxenda, Trulicity, Victoza and Wegovy they need to be stopped 3 days prior if taken daily, and it must be stopped 2 weeks prior if taken weekly, Also, if you take multi-vitamins, herbal supplements, Vitamin E, Fish oil or dietary products they need to be stopped 7 days prior. **If these medications are not stopped, your procedure will need to be rescheduled.**

Do not stop any high blood pressure medications, only take 1/3 of your diabetic medication the day before your procedure. Do not take any medications besides blood pressure the morning of your procedure.

Three days before your procedure you will need to stopped eating high fiber foods such as popcorn, beans, seeds (flax, sunflower and quinoa) multigrain bread, nuts, salad, vegetables and fresh or dried fruit.

The day before your colonoscopy/surgery _____
****You may only have clear liquids and clear liquids only the day prior to your colonoscopy/surgery****
Some examples of clear liquids are: water, apple juice (not apple cider), white grape juice, coffee, tea,(sweeteners are okay, no milk) Jell-O, popsicles, Gatorade, Crystal Light, Kool-Aid, Sprite, 7-Up, Vernors and Ginger Ale. (Nothing Red, Blue or Purple) Soup broths like chicken or beef without meat, rice, noodles or vegetables. **You may not have any solid food, milk or milk products the whole day prior to your procedure.**

You will need to purchase **4 Dulcolax tablets (laxative not softeners) 238 grams of Miralax powder and 1 bottle of citrate of magnesium** (available over the counter)

1. Take 4 Dulcolax tablets in the morning when you get up.
2. Between 2pm and 5pm mix the 238g of Miralax powder with 64oz of clear liquid and drink 8oz every 15 minutes until gone.
3. If stools are not running clear a couple hours after you have finished the Miralax prep you will need to drink 1 bottle of Citrate of Magnesium.

Clear liquids must be stopped by 10pm and nothing by mouth the day of your exam
You will be sedated and will need a driver to and from the facility
If you need to cancel this procedure please call our office 7 days in advance or you may be charged a $45 cancelation fee

DR. GANESH DESHMUKH, DR. ADEWUNMI ADEYEMO & DR. VISHNU PEMMARJAU

LAST NAME_____**FIRST NAME**_____**DATE OF BIRTH**_____

HEIGHT_____**WEIGHT**_____**LAST BLOOD PRESSURE**_____**OR UNKNOWN (circle if unknown)**

REASON FOR VISIT _____

DURATION OF PROBLEM (CIRCLE)_____ DAYS WEEKS MONTH YEARS

SEVERITY (CIRCLE) MILD MODERATE SEVERE

ARE YOU CURRENTLY TAKING (CIRCLE) ASPIRIN COUMADIN PLAVIX NONE

PLEASE LIST CURRENT MEDICATIONS

_____

_____

PLEASE LIST DRUG ALLERGIES: _____

LATEX ALLERGY? (CIRCLE) **YES** **NO**

DIET FIBER INTAKE? (CIRCLE) **LOW** **MODERATE** **HIGH**

ANORECTAL PROBLEMS (CIRCLE) **YES** **NO**
BRIGHT RED RECTAL BLEEDING BURNING AFTER BM MUCOUS PROTRUSION ITCHING
GUIAC POSITIVE STOOL

CAN YOU HOLD YOUR BOWELMOVEMENTS? (CIRCLE) **YES** **NO**
IF NOT, IS YOUR LOSS OF CONTROL: SOLID LIQUIDS FLATUS

ABDOMINAL PROBLEMS? (CIRCLE) **YES** **NO**
NAUSEA VOMITTING DIARRHEA CONSTIPATION BLOATING PAIN
IF PAIN, WHAT LOCATION? LOWER ABDOMEN UPPER ABDOMEN RIGHT SIDE LEFT SIDE

NEUROLOGICAL ILLNESS? (CIRCLE) **YES** **NO**
DIZZINESS WEAKNESS
IF DIZZINESS OR WEAKNESS, WHAT LOCATION? FACE TRUNK EXTEMITIES

CARDIOVASCULAR ILLNESS? (CIRCLE) **YES** **NO**
CHEST PAIN SHORTNESS OF BREATH DIFFICULTY BREATHING ON EXERTION

RESPIRATORY ILLNESS? (CIRCLE) **YES** **NO**
COUGH HEMOPTYSIS ASTHMA ATTACKS

URINARY SYMPTOMS? (CIRLE) **YES** **NO**
PYURIA (PUS IN URINE) HEMATURIA (BLOOD IN URINE) BURNING WHILE URINATING

DO YOU HAVE LIVER DISEASE? (CIRCLE) **YES** **NO**
JAUNDICE ITCHING BILARY COLIC FEVER BLEEDING DISORDER

DO YOU HAVE MUSCULOSKELETAL PROBLEMS? (CIRCLE) **YES** **NO**
JOINT PAIN SWELLING/NODELS(LUMPS) LEG PAIN DIFFICULTY WALKING

MEDICAL HISTORY - HAVE YOU OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR N

ANEMIA	YES/NO		**CANCER**	YES/NO	**TYPE?** _____
COPD	YES/NO		**COLON POLYPS**	YES/NO	
STROKE	YES/NO		**CHRONIC RENAL INSUFFCIENCY**		YES/NO
GERD	YES/NO		**CORONARY ARTERY DISEASE**		YES/NO
COLITIS	YES/NO		**OSTEOPOROSIS**		YES/NO
DEFIBRILLATOR?		YES/NO	**DIABETES MELLITUS**	YES/NO	**TYPE?**_____
HIGH BLOOD PRESSURE		YES/NO	**HEART PROBLEMS**	YES/NO	
KIDNEY DISEASE		YES/NO	**CROHN'S DISEASE**	YES/NO	
PACEMAKER?		YES/NO	**OTHER:**		

SURGICAL HISTORY - HAVE YOU OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR N

ANGIOPLASTY	YES/NO	**APPENDECTOMY**	YES/NO
C – SECTION	YES/NO	**CHOLECYSTECTOMY**	YES/NO
HERNIA REPAIR	YES/NO	**TUBAL LIGATION**	YES/NO
COLECTOMY	YES/NO	**HYSTERECTOMY**	YES/NO
OTHER:			

HEALTH MAINTENCE – PLEASE FILL IN DATE OF THE LAST PROCEDURE/EXAM, IF KNOWN

COLONOSCOPY/SIGMOIDOSCOPY? YES/NO DATE? _____

STOOL OCCULT CARDS? YES/NO DATE? _____

FAMILY HISTORY – PLEASE LIST FAMILY MEMBER(S) WHO HAD/HAVE THE FOLLOWING:

BREAST CANCER _____

COLON CANCER _____

PROSTATE CANCER _____

OVARIAN CANCER _____

OTHER CANCER – TYPE? _____

SOCIAL HISTORY - HAVE YOU OR DO YOU CURRENTLY DO ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

DO YOU CURRENTLY SMOKE?	YES/NO	**FORMER SMOKER?**	YES/NO
DO YOU USE RECREATION DRUGS?	YES/NO	**IF YES, PLEASE LIST**	_____
DO YOU DRINK ALCOHOL?	YES/NO		
DO YOU EXERCISE REGULARLY?	YES/NO		
ARE YOU SEXUALLY ACTIVE?	YES/NO	**IS YOUR PARTNER:**	MALE/FEMALE

DR. GANESH DESHMUKH, DR. ADEWUNMI ADEYEMO & DR. VISHNU PEMMARAJU

NAME _____

GENDER: MALE / FEMALE / OTHER_____(PLEASE CIRCLE) **DATE OF BIRTH**_____

ADDRESS_____**PHONE NUMBER** _____

CITY _____ **STATE** _____ **ZIP CODE** _____ **EMAIL** _____

MARTIAL STATUS: DIVORCED/LEGALLY SEPARATED/MARRIED/SEPARATED/SINGLE/WIDOWED (CIRCLE)

PHARMACY NAME AND PHONE NUMBER_____**PHONE**_____

REFERRING DOCTOR (FIRST & LAST NAME)_____**PHONE** _____

PRIMARY CARE DOCTOR (FIRST & LAST NAME)_____**PHONE**_____

EMERGENCY CONTACT NAME_____**PHONE**_____

RACE: WHITE, BLACK, ASIAN, HISPANIC/LATION, MIDDLE EASTERN/NATIVE HAWAIIAN/PACIFIC/OTHER
(PLEASE CIRCLE)

HEALTH INSURANCE COVERAGE

INSURANCE #1_____

CONTRACT #/ID#
OR ENROLLEE ID_____

GROUP NUMBER_____

SUBSCRIBER_____

SUBSCRIBER DATE OF BIRTH_____

INSURANCE #2_____

CONTRACT#/ID#
OR ENROLLEE ID _____

GROUP NUMBER _____

SUBSCRIBER _____

SUBSCRIBER DATE OF BIRTH _____

MEDICAL INFORMATION RELEASE

THE OFFICE OF DR. GANESH DESHMUKH, DR. ADEWUNMI ADEYEMO, & DR. VISHNU PEMMARAJU MAY DISCUSS MY MEDICAL CONDITION/INFOMRATION WITH THE FOLLOWING:

NAME/RELATIONSHIP

_____

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

THIS INFOMRATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES, CO-INSURANCES AND SERVICES RENDERED NOT COVERED BY MY INSURANCE. I WILL BE RESPONSIBLE FOR ANY NSF FEES AND MY BALANCE MAY DEFAULT TO COLLECTIONS IF NOT PAID WITHIN 90 DAYS OF RECEIPT OF STATMENT. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO MICHIGAN HEALTHCARE PROFESSIONALS, P.C. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION WHEN NECESSARY. I HAVE READ THE FULL FINANCIAL POLICY AND AGRESS TO THE TERMS. I HAVE BEEN GIVEN ADEQUATE ACCESS TO INFORMATION REGARDING HIPAA BY THIS OFFICE.

PATIENT/RESPONSIBLE PARTY SIGNATURE_____**DATE**_____

Ganesh Deshmukh, MD
Adewunmi Adeyemo, MD
Vishnu Pemmaraju, MD

3106 S Wayne Rd.
Wayne, MI 48184
734-722-6300
734-722-4815 Fax

Effective 10/01/2023

Office policies:
We are open Monday - Friday 8am-4pm. Our office is closed for 1 hour for lunch and that time varies daily. Office hours and appointments vary for each surgeon.
Please respect our office staff. Any type of abuse against our office staff will not be tolerated and may result in removal from the building and or termination of the practice.
Telephone calls are handled by our receptionists who are trained to ask and answer pertinent questions, and your cooperation will greatly speed up the process. They will either answer your questions, take a message, or make an appointment when deemed necessary. If you reach our voicemail, please leave a message and your call will be returned within one (1) business day. If you do not leave a message, we do not know that you called. Leaving a message will always be in your best interest.
Please DO NOT call the physicians for NON-EMERGENT MATTERS (Prescription refills, lab or test results, making an appointment, scheduling surgery, etc. THESE ARE NOT EMERGENT). If you call for NON-EMERGENT MATTERS, they will tell you to call the office.
Appointments can be made by calling our office during normal business hours. Please arrive 10 – 15 minutes before your scheduled appointment time to fill out new patient paperwork. Updating paperwork may be required at your appointment. Please contact us in advance if you are unable to make an appointment or may be late.
As a surgical practice, emergency situations arise that may result in the physician being called away. As a result, your appointment may need to be rescheduled or the physician running late. During these times, we appreciate your patience and understanding.

Medical records:
Medical records may be obtained, and the request can be processed if you have a signed medical record release form. Please allow up to 5-7 days for processing. There is no charge to send records to other physicians. There is a $15 charge to request personal medical records.

Prescriptions:
Prescriptions are renewed during normal office hours. In some instances, we may require that the patient be seen in our office prior to medication renewal. Please note, it may take 48 to 72 hours to process the prescription refills.

Financial Policy:
All Specialist office visit copays are due at the time of service. Please do not argue with the staff about your specialist copay. Your policy is between you and your Insurance Company.
$45 charge for last minute cancellation/no show charge for colonoscopies or surgical procedures.
There is a $25 charge for Disability/FMLA paperwork (allow 5-7 day turnaround for forms to be completed.) $50 Charge For expedited Disability/FMLA paperwork to be filled out within 24 hours or request. There is a $15 charge for Medical Records.
We accept cash, checks, Visa, MasterCard, and Discover. Please contact our billing office at 734-722-1063 if you should have any financial questions or concerns.

I have read and understand the office policies indicated above.

Printed patient name _____

Patient signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

Division of Michigan Healthcare Professionals, P.C.

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review this document carefully.

Your Rights

Get an electronic or paper copy of your medical record.

- You can ask to see or have an electronic or paper copy of your medical record and other health information we have about you. Please talk to one of our staff members.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Please talk to one of our staff members.
- We may refuse your request, but we'll tell you in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will approve all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may deny if it would affect your care.
- If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will approve your request unless a law requires us to share that information.

Obtain a list of those with whom we've shared information.

- You can request a list (accounting) of the times we've shared your health information for 6 years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Obtain a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated. Please contact our Privacy Official at 734-722-1063.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you don't have a clear preference for how we share your information in the situations described below, talk to one of our staff members. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes.

- Sale of your information.

- Most sharing of psychotherapy notes.

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you.
- Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Bill for your services. We can use and share your health information to bill and receive payment from health plans or other entities.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers.

Help with public health and safety issues.

We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research. We can use or share your information for health research.

Comply with the law.

-We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if they want to see that we're complying with federal privacy laws.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, and/or funeral director when an individual dies.

Address worker's compensation, law enforcement, and other government requests. We can use or share health information about you:

- For worker's compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: ww.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Contact our office at 734-722-1063 at any time with questions or concerns.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

_____ _____

Patient, Parent or Guardian Signature Date

Documentation of failure to obtain signed acknowledgement.

_____ _____

Patient name Reason

_____ _____

Office staff signature Date

Ganesh Deshmukh, MD
Adewunmi Adeyemo, MD
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3106 S Wayne Rd.
Wayne, MI 48184
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Authorization and Agreements of Medical Treatment
Insurance Benefits and Financial Responsibility

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Ganesh Deshmukh, MD or Adewunmi Adeyemo, MD, or Vishnu Pemmaraju, MD. or their associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow up examinations to check abnormalities found and treated lies with me and not my physician, thereby releasing my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Ganesh Deshmukh, MD, Adewunmi Adeyemo, MD, or Vishnu Pemmaraju, MD or their associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatment that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given to anyone as to the results that may be obtained by such treatments.

1. **All co-payments are due at time or service. We accept cash, check, Visa, Mastercard, Discover and Care Credit.**

2. **All balances must be paid prior to any office visits or surgeries being scheduled.**

3. **Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance company are your responsibility.**

4. **Your doctor is here to manage your medical care. The Physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial difficulties with the billing department. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.**

I have read the above Acknowledgment and Agreements and fully understand the same.

Patient's Name (Print) _____

Signature of patient or Guardian_____Date: _____

Relationship to patient_____Witness_____Date: _____