



Welcome to the Family Medical Center of MI, Inc.!

The Family Medical Center is dedicated to providing high quality, affordable and comprehensive health care and dental services using a team-based, patient-centered approach in which you are the most important member of your healthcare team.

Below is some important information we'd like to provide you as a new member of our Community Health Center. Please review and fill out the attached forms for our records.

LOCATIONS AND HOURS OF OPERATION

Office hours vary by provider. Below are general operating hours at each of our locations.

Temperance Office

8765 Lewis Ave
Temperance, MI 48182
(734) 654-2169

Medical Hours

Mon – Tues – Fri (8:00am – 5:00pm)
Wed & Thurs (8:00am – 8:00pm)

Dental Hours

Mon and Fri (8:00am – 5:00pm)
(734) 850-6920

Southgate Medical Office

13101 Allen Rd.
Building 4 Entrance C
Southgate, MI 48195
(734) 654-2169
Wed (8:00am – 5:00pm)

Carleton Office

130 Medical Center Dr.
Carleton, MI 48117
(734) 654-2169

Medical Hours

M, Tue, Thurs, F (8am-5pm)
Wed (8:00am-8:00pm)

Dental Hours

Mon-Fri (8:00am-5:00pm)
(734) 850-6920

Monroe Medical Office

901 N. Macomb St. Suite 109
Monroe, MI 48162
(734) 654-2169
Mon - Fri (8:00am – 5:00pm)

Adrian

1200 N. Main
Adrian, MI 49221
(517)263-1800

Medical Hours

Mon & Fri (8:00am-5:00pm)
Tues, Wed & Thurs (8am-7pm)

Dental Hours (734)850-6920

Mon-Tue-Fri (8:00am-5:00pm)
Wed & Thurs (8:00am – 6:00pm)

Monroe OB/GYN Office

901 N. Macomb St Suite 109
Monroe, MI 48162
(734) 654-2169
Monday (11:00am-7:00pm)
Tuesday (8:00am-12:00pm)
Wed & Thurs (9:00am-4:00pm)
Friday (8:00am-12:00pm)

Ensuring you have full access to your healthcare team is important to us and therefore same day appointments and next day appointments are available for patients with urgent needs.

TELEPHONE CALLS AND PRESCRIPTIONS

All non-urgent phone calls will be returned within 48 hours. In some cases, an appointment may be required to address your concern. Outside of regular office hours, an on-call provider can be reached by calling one of the office numbers listed above. In case of emergency, call 9-1-1 or go to your nearest emergency room.

To assure that you receive prescription refills in a timely manner, we ask that you call your pharmacy and request a prescription refill authorization request be submitted to FMC electronically. This must be done **AT LEAST 7 DAYS** before the refill is needed. Some patients may be required to be seen by their provider to receive their refills.

DISCOUNTED SERVICES - FMC serves all individuals regardless of insurance. Please complete the attached Application for Discounted Services. To complete the application process, you will need to provide all household income.

Transportation: Need help with transportation? We can help facilitate a referral to a partner organization or assist with Medicaid transportation services.



WELCOME TO YOUR NEW MEDICAL HOME!

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

We will:

- Ask what your goal is, or what you want to do to improve your health
- Ask you to help us plan your care, and to let us know if you think you can follow the plan
- Create written copies of care plans for more complex illnesses
- Have the care team members doing more or different parts of care
- Remind you when tests are due, so you can receive the best quality care
- Ask you to have blood tests done before your visit so that doctor has the results at your visit
- Explore methods to care for you better; including ways to help you care for yourself

We trust you, our patient to:

- Tell us what you know about your health and illnesses
- Tell us about your needs and concern
- 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 medications 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 tell us what medications they put you on 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 is covered
- 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 feedback so we can improve our services (We may survey you in the future to understand this better.)

We will continue to:

- Provide you with a care team who will know you and your family
- Respect you as an individual—we will not make judgments 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 lead by your physician
- 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 seven days a week
- Take care of short illness, 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 in the near future we will use technology like our Electronic Health Record and we will strive to continuously improve.



Please Circle all that apply

Marital Status: Divorced Married Partner Single
Widowed Legally Separated Unknown

Language Preference: English Spanish Other: _____

Race: Asian Native Hawaiian Other Pacific Islander Black/African American
American Indian/Alaska White Unreported/Refused to Report

Ethnicity: Declined to Specify Hispanic or Latino Not Hispanic or Latino

Employment Status: Full Time Part-Time Not Employed Self-Employed
Active Military Duty Retired Unknown Reserved for National Assignment

Student Status: Full-Time Part-Time Not a Student

Name of Responsible Party

Self (all information same as Patient Demographic)

Other: FMC patient: Yes No

_____ Last First Middle Suffix

Responsible Party SS # _____ Responsible Party Date of Birth _____

Main Phone () _____

Email address: _____

Gender: Male Female

Address _____
Number & Street City State Zip Code



Employer Information

Responsible Party Employer: _____

Employer Address: _____

Employer Phone Number: _____

OK to leave a message at work: Yes No

Please Circle all that apply

Veteran: Yes No

Seasonal Worker: Yes No

Migrant Worker: Yes No

Homeless: Yes No

If Yes, please select: Unknown Street Doubling Up Transitional Housing
Homeless Shelter Other: _____

Limited English: Yes No

Public Housing: Yes No

How did you hear about us:	Facebook/Social Media	News Media
FMC website/Internet	Word of mouth (friend, family)	Direct Mailing
Insurance	Health Department (DHHS)	Other



Consent for Treatment

Patient Name (print): _____ D.O.B. _____

I hereby request and authorize the staff of Family Medical Center of Michigan, using the facilities of Family Medical Center of Michigan, to administer any treatment deemed necessary and advisable for my care until revoked in writing.

I am aware that Family Medical Center does obtain prescription information from other sources.

Signature: _____ Date: _____

Emergency Contact Information

Name: _____ FMC patient: Yes No

Phone Number: _____ Relationship: _____

Address: _____ City: _____ Zip Code: _____

I, _____, give permission to the name listed above, to communicate verbally or in writing with the staff at Family Medical Center about patient care: Including. But not limited to, appointments, medical messages, assessments and prescriptions until revoked in writing.

(Patient/Parent Signature)

(Date)



Insurance Information

Patient Name _____

Primary Insurance _____

Contract Number _____ Group Number _____

Policy Holder Name _____

Secondary Insurance _____

Contract Number _____ Group Number _____

Policy Holder Name _____

I authorize Family Medical Center of Michigan to release any information necessary to process any medical claims for services provided to myself or family members covered by my insurance policy or required by regulatory or accrediting organizations. I authorize payment of medical benefits be made directly to Family Medical Center of Michigan.	
Signature	Date

I understand that I will receive a statement of my account while my insurance is being billed, until it has been paid in full by my insurance or myself.	Initial
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I understand that, if my insurance has not paid a claim within 45 days from the date of service, that I am responsible for contacting my insurance company and/or pay the bill myself.	Initial
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I understand that I am responsible for my charges at Family Medical Center of Michigan whether I am self-pay, receiving discounted services, or if my insurance does not pay for the charges incurred at Family Medical Center of Michigan.	Initial
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Child/Adolescent Consent for Treatment

I hereby request and authorize the staff of Family Medical Center of Michigan, using the facilities of Family Medical Center of Michigan, to administer any treatment deemed necessary and advisable for my child's care until revoked in writing.

Signature: _____ Date: _____

Minor Treatment Permission Form

I, _____, give permission to allow the following person or persons:

To bring in _____
(Name of Patient) (Date of Birth)

- My Child (if full/partial custody/shared parenting, **legal documentation is required**)
- Foster Child (**legal documentation is required**)
- Legal Dependent (**legal documentation is required**)
- Person under my legal medical care (**legal documentation is required**)

Using the facilities of the Family Medical Center of Michigan to administer any treatment deemed necessary and advisable for my child's care if I am unable to accompany my child until revoked in writing

I also understand that the Family Medical Center, by federal law, has the right to request documentation of proof of guardianship, legal medical authority and proof of identification (photo identification) of said persons.

(Patient/Parent/Legal Guardian Signature)

(Date)

(Employee Witness)

(Date)



Medication/Documentation Pick-Up Permission Form

I, _____, give permission to allow the following person/persons

To pick up any prescription(s), medication samples, work notes, school notes, forms and/or any other documentation on my behalf until revoked in writing. I understand that should these items get lost or not end up in my possession after being picked up by said person(s) listed above, they may not be refillable or replaced by the Family Medical Center.

(Patient/Parent Signature)

(Date)

(Employee Witness)

(Date)

Communications Permission Form (HIPAA Authorization)

I, _____, give permission to the following person or persons

To communicate verbally or in writing with the staff at Family Medical Center about patient care; including, but not limited to, appointments, medical messages, assessments and prescriptions until revoked in writing.

(Patient Name)

Date of Birth

(Patient/Parent Signature)

(Date)

(Employee Witness)

(Date)





Expiration Date: _____
 SF Category _____
 Account # _____

**FAMILY MEDICAL CENTER OF MICHIGAN, INC
 APPLICATION FOR DISCOUNTED SERVICES**

The Family Medical Center of Michigan offers discounted services to our patients who are without medical insurance or coverage for services. These discounted services are determined based on all of your household’s pre taxable income and number of occupants. An evaluation of your income is conducted to calculate the percentage of our fees, which will be charged to you. **Your payment is due at each date of service.**

In order to be considered for discounted services, you will need to complete this application and **present proof of all household income. See page 2 for required types of income to be reported.** You have ten days to provide us with your proof of income. Failure to complete and return all required documentation will result in no discount and you will be responsible for the bill in full and subject to collection if not paid.

I understand that the Discounted Services Program, offered by the Family Medical Center of Michigan, is funded by a grant from the United States Public Health Service. I certify that the information contained in this application and the attached proof of income is true. I authorize Family Medical Center of Michigan to verify all information reported in these documents.

Patient name: _____

Address: _____ DOB: _____

City, State, Zip: _____ County: _____

Telephone #: (____) _____ SSN#: _____

Signature _____ Date _____

<u>Names of Adults in Household</u>	<u>Employed</u>	<u>Names/Ages of Children in Household</u>
1. SELF _____	Y/N	1. _____
2. _____	Y/N	2. _____
3. _____	Y/N	3. _____
4. _____	Y/N	4. _____
5. _____	Y/N	5. _____

You must list all persons living in your household and their income.

Are you a patient in Medical? Y N Are you a patient in Dental? Y N

Employee completing application: _____

Supervisor review: _____ Date: _____

Insurance: Y N



Please mark all applicable income for your household:

	YES	NO
Wages/Salary 2-3 paychecks stub current years taxes	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Copy of bank statement	<input type="checkbox"/>	<input type="checkbox"/>
Workers compensation Award letter	<input type="checkbox"/>	<input type="checkbox"/>
Public Assistance Award letter from DHS	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment Benefits Approval letter from State	<input type="checkbox"/>	<input type="checkbox"/>
Income from rental property Taxes	<input type="checkbox"/>	<input type="checkbox"/>
Pension/Veteran Benefits/Retirement Copy of bank statement	<input type="checkbox"/>	<input type="checkbox"/>
Alimony or child support	<input type="checkbox"/>	<input type="checkbox"/>
Income from Royalties, estates, trusts, educational assistance	<input type="checkbox"/>	<input type="checkbox"/>

To apply for the discounted services, you will need to provide proof of all income selected. Failure to provide all forms of income will result in disqualification for this program and discounts.

Employee Initials: _____



Financial Policy

As a courtesy to our patients, Family Medical Center of Michigan will file your insurance claim with your primary insurance carrier. Family Medical Center of Michigan will supply you, upon request, with all pertinent information to assist in the filing of a claim to your secondary insurance carrier, or we will be glad to file those secondary insurance claims for you on a one-time basis.

To alleviate any misunderstanding regarding insurance payments, all patients must assign their primary insurance company directly to Family Medical Center. If you want the primary insurance company to pay you directly, Family Medical Center of Michigan will require full payment prior to service being rendered. Secondary insurance payments filed by Family Medical Center of Michigan must be assigned directly to Family Medical Center of Michigan. You will be responsible for all balances not covered by your primary or secondary insurance company.

Michigan law requires that insurance companies pay medical practices within a reasonable amount of time (45 days). If a problem persists, we will ask you to assist us in contacting your insurance carrier. Your insurance coverage is a contractual relationship between you and your insurance carrier, not Family Medical Center of Michigan and your insurance carrier (with the exception of managed care patients). Therefore, all claims not paid within a reasonable amount of time (45 days for "clean claims") will become your responsibility, for which you will receive a bill.

All patients must read and sign Family Medical Center of Michigan's written financial arrangement prior to services being rendered. Our staff will make every effort possible to clarify any misunderstanding that should occur concerning account balances.

Family Medical Center of Michigan's goal is to create an excellent physician/patient relationship.

Family Medical Center of Michigan uses the following guidelines regarding financial payment:

1. All Patients must read and sign Family Medical Center of Michigan's financial agreement Prior to services being rendered.
2. Insurance payments that have not been received within 60 days after filing will be turned over to the patient's responsibility.
3. The practice, at its sole discretion, may establish weekly/monthly payment arrangements to accommodate individual patient needs.
4. Patients will receive a statement of account each month indicating the amount that is the patient's responsibility. Payment of your balance is due within 30 days.
5. If you feel that your insurance company has not paid correctly, it is your responsibility to contact them.
6. Patients who do not remit payment in full will be turned over to collection agency. Patients with payment arrangements must comply with their monthly payment plan. Failure to do so will result in turnover to collection agency.
7. Co-Payments are required before services are rendered.
8. If you do not have insurance or have a sliding fee, payment in full is expected at time of service unless you have made prior payment arrangements with our patient accounts department.



9. If you have a delinquent account, you will be required to make a payment on your balance in addition to current service before services are rendered.
10. For patients who are eligible for Medicare, we are “participating physicians.” This means that we accept Medicare’s allowed charge for the services rendered, eliminating the difference between what we charge and what Medicare approves. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for 20% of the approved charge, plus any deductible . If you have secondary insurance, we will submit a claim to them once for any remaining balance after Medicare has paid. Please remember that although we will accept assignment for Medicare patients, the beneficiary, as required by federal law, is responsible for 20% of the approved amount and also for any routine services not covered Medicare.
11. In cases of divorce, the parent seeking treatment is ultimately responsible for payment of the bill unless we receive legal documentation stating otherwise.

About Our Notice Of Privacy Practices

Family Medical Center is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your person health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in the Notice
- The person to contact for further informaiton about our privacy practice.

Family Medical Center is required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.



Patient Name: _____ D.O.B. _____

Patient Acknowledgement of Receipt of Policies and Practices

I hereby acknowledge that I have received a copy of Family Medical Center of Michigan’s Notice of **Privacy Practices**.

Provider records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges. This organization participates in the Great Lakes Health Connect (GLHC) information network and Commonwell/Carequality. All have rules regarding how health information can be accessed and limits on use or disclosures of that information. For more information and your rights associated with transmission of your information through these health information exchanges, please contact: Jamie Ferguson, Privacy officer at 734-850-6919.

Patient Signature _____ Date _____

Parent or Patient Representative Signature _____ Date _____

Description of Legal Authority to act on behalf of Patient

I hereby acknowledge that I have received a copy of Family Medical Center’s Financial Policies

Patient Signature _____ Date _____

Parent or Patient Representative Signature _____ Date _____

Description of Legal Authority to act on behalf of Patient





PERSONAL HEALTH REVIEW

Today's Date: _____

Name: _____

Current Address: _____

Home Phone: _____

Date of Birth ____/____/____

Withholding essential health information such as allergies, past procedure etc. may affect the outcome of treatment.

Do you have any allergies to medication, environment or food?	<input type="checkbox"/> yes <input type="checkbox"/> no	Please list:
Have you seen your primary care provider in the last year?	<input type="checkbox"/> yes <input type="checkbox"/> no	List dates:
Have you been hospitalized in the past year?	<input type="checkbox"/> yes <input type="checkbox"/> no	List dates and reason:
Have you gone to the emergency room in the last year?	<input type="checkbox"/> yes <input type="checkbox"/> no	List dates and reason:
Do you know if your shots are up to date?	<input type="checkbox"/> yes <input type="checkbox"/> no	If no, explain:
Do you smoke or chew tobacco?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, how much per day:
Do you drink alcohol?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, how much per day:
Are you currently using illegal substances or Medical Marijuana?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, which ones:
Are you sexually active?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you seen a Dentist in the last 6 months?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, last visit:
Do you have any current dental problems?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, explain:
Do you use special equipment? (Ex. Wheelchair, lift, walker)	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, explain:
Do you have a special diet? (Ex. Low salt, diabetic)	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, explain:



	Have you ever been told that you have...	Have your biological parents ever been told that they have....
High blood pressure?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Hepatitis?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
High Cholesterol?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Heart Attack/Heart Disease?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
High Blood Sugar?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Irritable Bowel Syndrome?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Asthma?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Cancer? Type:	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Anemia?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Stroke?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Thyroid Disease?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
Urinary Tract Infection?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother
HIV/AIDS?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> father <input type="checkbox"/> mother

Check all that apply:

<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Bruise easily or anemic	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Finger or toe nail problems	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Painful or difficulty urinating
<input type="checkbox"/> Confused or forgetful	<input type="checkbox"/> Chest pain or chest tightness	<input type="checkbox"/> Swollen ankles or feet	<input type="checkbox"/> Muscle stiffness or pain
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Breathing/lung problems	<input type="checkbox"/> Weak or tired all the time	<input type="checkbox"/> Shaking or trembling
<input type="checkbox"/> Mouth or teeth problems	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Rashes or sores that do not heal	<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Eye or vision problems	<input type="checkbox"/> Positive TB test	<input type="checkbox"/> Always Thirsty	<input type="checkbox"/> Seizures
<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Dizzy or frequent falling
<input type="checkbox"/> Diarrhea or constipation	<input type="checkbox"/> Frequent cold or coughing	<input type="checkbox"/> Stomach pain or upset stomach	<input type="checkbox"/> Recent weight gain or loss
<input type="checkbox"/> Changes in moles or skin	<input type="checkbox"/> Rapid or irregular heart beats	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Sleep too much

HEALTH MAINTENANCE SCREENING TESTS:

*Have you had these tests done?

Lipid (cholesterol)?	Yes ___ No ___	Date	Physician:
Colonoscopy?	Yes ___ No ___	Date	Physician:
Routine bloodwork?	Yes ___ No ___	Date	Physician:
Fecal occult blood test?	Yes ___ No ___	Date	Physician:

Women:

# pregnancies	# of Deliveries ___	# of Abortions ___	# of Miscarriages ___
Mammogram?	Yes ___ No ___	Date	Hospital:
Pap Smear?	Yes ___ No ___	Date	Physician:
Dexascan (osteoporosis)?	Yes ___ No ___	Date	Hospital:
Hysterectomy	Yes ___ No ___ Partial ___ Full ___	Date	Hospital:

Men:

PSA bloodwork?	Yes ___ No ___	Date	Abnormal? Yes ___ No ___
Prostate exam?	Yes ___ No ___	Date	Abnormal? Yes ___ No ___

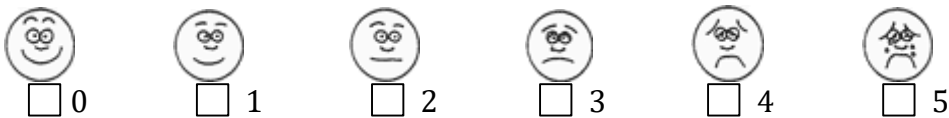
How do you learn best? (please circle)

Auditory (hearing/listening) Visual (read / see) touch (touch / do)

Do you regularly experience pain that interferes with your daily activities? Y___N___

Location of pain: _____

Please rate your level of pain:



Describe current/past treatment for pain, including names of providers:



List all surgeries you have had done:

Type of surgery	Year	Complications Yes ____ No ____	Additional comments

List all medications, over the counter medications and herbal remedies:

Medication Name	Dosage	Directions	Prescribing Doctor

Provider Signature _____ **Date** _____



Authorization to Release Medical Records

Patient Name: _____

Patient Address: _____ Date of Birth: _____

_____ Phone number: _____

1. I am the patient listed above and/or the legally authorized representative of the patient listed above. I request that protected health information be released:

From:

To:

Physician/medical facility authorized to DISCLOSE information

Person/Physician/Organization authorized to RECEIVE the information

2. Information should be on: and delivered via:

Paper

- Mail to above address
Picked-up by: _____ (ID is required for pick-up)
Fax# _____

3. Specific dates of service to be released: _____

4. Records to be released:

- Physician Office Pertinent Transfer package (standard two years of information)
Progress Notes Immunization Record Other: _____
Laboratory Results Billing Statements
Radiology Results Dental Record

- I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), Hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such person or entity and will likely no longer be protected by federal privacy regulations.
I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
In accordance to the State Law, unless otherwise revoked, for Michigan entities this authorization will expire in sixty (60) days.

Signature of Patient or Legally Authorized Representative: _____ Date: _____

Relationship to Patient: _____ Witness: _____

If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)

- Parent Durable Power of Attorney of Health Care Legally Authorized Representative
Personal Representative of the Estate Other (Specify and attach Proof) _____





Family Medical Center Patient Appointment Responsibility

As a courtesy to our patients a reminder call is sent out the day before your appointment to remind you of the time and the provider that you will see. In return we are asking our patients to be courteous and to give us a call if you are not able to make your scheduled appointment. Appointment times are very valuable to you, the provider and to other patients that may be waiting to schedule an appointment.

In the event that you do not call to cancel or reschedule, you will be considered a No Call No Show (NCNS). We will be giving you a call to ask how we can assist you in any way to keep your appointment. If three (3) NCNS's occur in a 12-month time period, you will only be able to set up a Same Day appointment for one (1) issue only. If no Same Day appointment is available, you will have to call the next day to check for Same Day appointment availability.

Thank you.



Notice of Privacy Practices

Effective: April 14, 2003

This Notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

For more information, please contact us:

Jamie Ferguson

Privacy Officer

8765 Lewis Avenue Temperance, MI 48182

(734) 847-3802

Who We Are:

This notice describes the privacy practices of Family Medical Center of Michigan, Inc. (FMC) and the privacy practices of:

- All of our Doctors, Nurses, and other health care professionals authorized to enter information about you into your medical record.
- All of our Departments, including, e.g., our medical records and billing departments.
- All of our Health Center sites- Temperance, Carleton, Monroe, Adrian.
- All of our employees, staff, volunteers, and other personnel who work for us on our behalf.

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all our records about your care, whether made by our health care professionals or others working in this office and tells you about the way in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

We are required, by law, to:

- Make sure that health information that identifies you is kept private in accordance with relevant law.
- Give you this notice of our legal duties and privacy practices with respect to your personal health information.
- Follow the terms of the notice that is currently in effect for all of your personal health information.

How We May Use and Disclose Your Health Information:

We may use and disclose your personal health information for these purposes:

- **For Treatment.** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to the doctors, nurses, technicians, medical students and others who are involved in your care. They may work at Family medical Center, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy or other health care provider to whom we may refer you for treatment, consultation, x-rays, lab tests, prescriptions or other health care services. They may also include doctors and other health care professionals who work at the Family Medical Center, or elsewhere, whom we consult about your care. For example, we may consult with a specialist who lends his/her services to the Family Medical Center about your care or disclose to an emergency room doctor who is treating you for a broken leg that you have diabetes, because diabetes may affect your body's healing process.
- **For Payment.** We may use and disclose health information about you to bill and collect payment from you, your insurance company, including Medicaid and Medicare, or other third party that may be available to reimburse us for some or all your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you need to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day operations and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations. These uses, and disclosures are necessary to run the Family Medical Center and to make sure that all our patients receive quality care, and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients with health information from other health care providers to decide what additional services the Family Medical Center should offer, what services are needed, whether new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information, so others may use it to study health care delivery without learning who our patients are.
- **Appointment Reminders.** We may use and disclose health information about you to contact you as a reminder that you have an upcoming appointment at the Family Medical Center.

- **Health-Related Services and Treatment Alternative.** We may use and disclose health information to tell you about health-related services or recommend treatment options and alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address when sending this information to you.
- **Fundraising Activities.** We may use health information about you to contact you to raise money for our not-for-profit operations. We may disclose health information about you to a foundation related to the Family Medical Center so that the foundation may contact you in raising money for the Family Medical Center. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services from us. Please let us know if you do not want us to contact you for fundraising efforts.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to a friend or family member who is involved in your health care or the person who helps pay for your care.
- **Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with a patient's need for privacy. Before we use or disclose health information for research, the project will have been approved through this special approval process, although we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask you for specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care.
- **Organ or Tissue Donation.** If you are an organ donor, we may disclose health information about you to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **As Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosures, however, would only be to someone able to help prevent the threat.

- **Military and Veterans.** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veteran Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.
- **Worker's Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Public Health Activities.** We may disclose health information about you for public health activities. These activities generally include the following:
 - To prevent or control disease.
 - To report births and deaths.
 - To report child abuse or neglect.
 - To report reactions to medications or problems with products.
 - To notify people of recalls of products.
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
 - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose health information about you to a health oversight agency for activities authorize by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
- **Lawsuits and Disputes.** We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process that is not accompanied by a court or administrative order, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law enforcement.** We may release health information about you if asked to do so by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons, or similar process.
 - To identify or locate a suspect, fugitive, material witness or missing person.
 - Under certain limited circumstances, about the victim of a crime.
 - About a death we believe may be the result of criminal conduct.
 - About criminal conduct at the Family Medical Center.
 - In emergency circumstance to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

- **Coroners, Health Examiners, and Funeral Directors.** We may release health information about our patients to a coroner or health examiner. This may be necessary, for example, to identify a deceased person, or determine the cause of death. We may also release health information to funeral directors as may be necessary for them to carry out their duties.
- **National Security and Intelligence Activities.** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the corrections institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the corrections institution.

Your Rights:

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them:

Rights to Inspect and Copy. You have the right to inspect and copy the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of applicable fee, provide you with a summary of these notes.

To inspect and copy your personal health information, you must submit your request in writing to our privacy contact person identified on the first page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of this review. Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.

Right to Amend. If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for any information that we maintain about you. To request an amendment, your request must be made in writing, submitted to our privacy contact person identified on the first page of this notice, and must be contained to one piece of paper legibly

handwritten or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or organization that created the information is no longer available to make the amendment.
- Is not part of the health information kept by or for the Family Medical Center.
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to the health care professionals involved in your care and to others to carry out payment and health care operations, as previously described in this notice.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your health information that we have made. Any accounting will not include all disclosures that we make. For example, an accounting will not include disclosures:

- To carry out treatment, payment and health care operations as previously described in this notice.
- Pursuant to your written authorization.
- To a family member, other relative, or friend involved in your care or payment for your care when you have given us permission to do so,
- To law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to our privacy contact person identified on the first page of this notice. Your request must state a time period, which may not be more than six (6) years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request or notify you if we are unable to supply the list within that time period and by what date we can supply the list; this date will not exceed 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we do agree, however, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing

to our privacy contact identified on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Receive Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way. For example, you can request that we only contact you at work or by mail to a specific address.

To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the first page of this notice.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing us a written description of your complain or by telling us about your complaint in person or over the telephone:

Jamie Ferguson
Privacy Officer
Family Medical Center of Michigan
8765 Lewis Avenue Temperance, MI 48182
(734) 847-3802

Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information:

Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and we are required to retain our records of the care that we have provided to you.