Eaton Rapids Medical Center Family Practice + Redicare

Springport Medical Clinic
Eaton Rapids Medical Center

New Patient Information

PERSONAL INFORMATION

Name:_____
Last First Middle

Address: _____

Zip: _____City: _____State: _____

Phone:_____Work phone:_____

Cell: _____

Employer: _____

Occupation:_____

Patients Gender: (Circle) Male or Female

Birth Date: _____ / _____ / _____

Social Security Number: _____

Marital Status (Circle): Single - Married - Widowed - Divorced

Email: _____

May we use this Email for *MyERMC* Patient Portal? Y / N

INSURANCE INFORMATION

Name of Subscriber:_____Subscriber's Birth Date: _____ / _____ / _____

Insured Address:_____

How patient is related to Insured: Self or Spouse or Child or Other: _____

Primary Insurance Co: _____Secondary Insurance Co: _____

ID Number: _____ID Number:_____

EMERGENCY CONTACT

Name:_____Relationship to Patient:_____
Last First Middle Initial

Address:_____ City:_____State:_____ Zip: _____

Primary Phone:_____Work Phone:_____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services rendered unless other payment arrangements have been made in advance with our office. The information above is correct to the best of my knowledge.

Date:_____Time: _____ Patient/ Guardian Signature: _____

Eaton Rapids Medical Center
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Springport Medical Clinic

Patient Name: _____ DOB: _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS AND PHONE MESSAGES

In order for our office to release medical information including test results to anyone else in your family including your spouse, an Authorization for Release of Information to Family Members and Phone Messages form must be signed. This protects your privacy rights and individual identifiable health information as required by the Health Information Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164.

Please list below the name and relationship of the individuals to whom we may release your health information. Any or all medical information regarding your medical condition, including but not limited to test results, may be given to the below-stated person with a properly executed Patient Authorization for Disclosure of Health Records form or verbally in person.

- *"Any" or "all" medical information released may include information regarding drug and/or alcohol treatment, social service or mental health records, communications made with a social worker, and HIV/AIDS and AIDS-related complex information if such information exists.*

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Additionally, I authorize my health information to be communicated to me by Eaton Rapids Medical Center Family Practice/Springport Medical Clinic via the checked option/s below, if any indicated.

- *I understand that phone numbers for below locations will be located within the electronic medical record and are maintained in accordance with Eaton Rapids Medical Center Family Practice/Springport Medical Clinic Policy.*

❒ Messages may be left on my home answering service

❒ Messages may be left on my cell phone

❒ Messages may be left on my work phone

- *I understand that I may revoke this authorization at any time by sending a written revocation to Eaton Rapids Medical Center Family Practice/Springport Medical Clinic except to the extent that Eaton Rapids Medical Center Family Practice/Springport Medical Clinic has taken action in reliance on the authorization.*
- *I understand that once my health information is used or disclosed pursuant to this release, it may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal or state law.*
- *I understand that my continued or future treatment by Eaton Rapids Medical Center Family Practice/Springport Medical Clinic is not conditional upon my providing or signing this release.*
- *This release is made in accordance with federal and state law and is valid for a period of one year after being executed.*

Date	*Patient Signature or Legal Guardian/Representative*	*Printed Name and/or Relationship to Patient*
Date	*Witness Signature*	*Witness Printed Name*

Office use only

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Eaton Rapids Medical Center

Living with chronic pain can be devastating, and effective pain management is important to getting your life back. For your health and wellbeing, Eaton Rapids Medical Center Family Practice and Springport Medical Clinic are improving the way opioids are prescribed so that we can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

It is essential that you and your health care provider discuss treatment options, carefully considering all of the risks and benefits. Some medications, such as prescription opioids, can help relieve pain in the short term, but also come with serious risks and potential complications—and should be prescribed and used carefully. Your health care provider will work with you to weigh benefits verses risks and create an appropriate plan to help you effectively manage your pain.

Before your health care provider first decides to prescribe opioid pain medications for you, we will need a drug screen and will obtain a report from Michigan's prescription monitoring program that shows which controlled substances, if any, have been prescribed for you in the past year. We require these items in order to make good decisions about your treatment.

Please note that at least once a year you will need to provide a urine or saliva sample for screening. We will also obtain a report from Michigan's prescription monitoring program, at least every 3 months, which outlines the prescriptions you have received from pharmacies.

As part of your opioid treatment plan, we will require that you sign a controlled substance agreement once a year. Please read this agreement carefully, as it has useful and detailed information that is not discussed in this policy letter.

To provide you with the best possible care, we will need to monitor your prescriptions. This will be done during scheduled office visits, independent of other medical problems. Most patients will need to be seen at least every one to three months.

Your prescriptions will be written to last until your next visit. If you have a problem with your condition between office visits, you should schedule an office visit with your health care provider at that time. Please note that opioid prescription refills will not be given over the phone unless you have arranged this ahead of time with your health care provider. Any medications that are lost or stolen will not be replaced.

Additionally, you will be expected to use other medical treatments to improve your pain. It may not be possible to completely remove all of your pain. However, our goal in many cases is to return your functionality to an accepted level. Your health care team is able to provide the best treatment for you if we have good communication. You and your health care providers should be respectful of each other for treatment to continue.

YOUR RESPONSIBILITIES

- Come to all of your appointments.
- Have your medical records sent to us.
- Safely keep track of your medications.
- Work with your health care team on other ways to improve your pain.
- Give a urine or saliva sample when asked.

OUR RESPONSIBILITIES

- Provide the best possible treatment for your condition.
- Work closely with you to set pain management goals and develop a treatment plan that will help you achieve your goals.
- Assess the risks and benefits of prescription opioids with you, and prescribe opioids only when their benefits outweigh their risks.
- Listen and respond to you.
- Review your medications for safe and effective dosing.
- Work with you to maximize your functionality.

Eaton Rapids Medical Center

Notice of Privacy Practices

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice is a summary of how we handle your health information.**

2. **How we may Use and Disclose your Health Information.** We use health information about you for treatment, payment, administrative purposes, to evaluate the quality of care that you receive, for other providers to whom you are referred, your family physician for continued care and for disclosures required by law, which may be disclosed without your consent. But beyond these situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any further uses and disclosures. Your information may be shared by paper, mail, electronic mail, fax, telephone/answering machine or other methods.

3. **Your Rights.**
   You have a right to request restrictions on certain uses and disclosures of your health information. We are not required to honor such request. You may also ask that we communicate with you confidentially, for example, sending information or notices to a special address, telephone restrictions, etc.

   You have the right to look at or receive a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You have the right to request an amendment of your health information, if you believe there is an error or information is missing.

   You also have the right to request a list of certain types of disclosures of your information that we have made.

4. **Our Legal Duty.** We are required by law to protect the privacy of your health information, provide this Notice about our privacy practices, follow the privacy practices that are described in this Notice, and seek your acknowledgment of receipt of this Notice. We may change our privacy policies at any time. Before we make a significant change to our policies, we will change our Notice and post the new Notice. You can also request a copy of our Notice at any time.

5. **Privacy Complaints.** If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint. The person listed below can provide you with the appropriate address upon request.

FOR MORE INFORMATION ABOUT OUR PRIVACY POLICIES, CONTACT THE PERSON LISTED BELOW:

Heather Schragg, Privacy Officer
Eaton Rapids Medical Center
1500 South Main
Eaton Rapids, MI 48827
Telephone: (517) 663-9442

For a complete copy of our Notice of Privacy Practices, please notify the Registration Staff or your nurse.

Eaton Rapids Medical Center Family Practice + Redicare

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NEW ADULT PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

MR #: _____ Date: _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please complete all questions. It is long because it is comprehensive. We really want to know you well so we can care for you properly. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it.

Who referred you to our practice? _____

What are your health goals for the next year? _____

_____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list healthcare providers and their specialty that you see regularly:

Provider: _____ Specialty: _____

Provider: _____ Specialty: _____

Provider: _____ Specialty: _____

Provider: _____ Specialty: _____

Which pharmacy do you use? ☐ Family Fare ☐ Meijer – Location: _____

☐ Rite Aid ☐ Rottenbuchers ☐ Other: _____

Medications

Please list **all** prescriptions and non-prescription medications. Include vitamins, herbs, supplements, home remedies, medical marijuana, birth control pills, inhalers, and over-the-counter pain pills (Advil, Aleve, Tylenol, etc).

☐ Check this box if you do not take any prescription or over-the-counter medications.

☐ Check this box if you brought a list of your medications to give to staff. Do not fill in table below.

Medication	Dosage	Frequency

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Name: _____ Date of Birth: _____

Allergies

Please list allergies to medications, tape/adhesives, or metals, and your reaction.

☐ Check this box if you do not have allergies.

Allergy	Reaction

Routine Medical Examinations/Screenings

Health Maintenance	Recommendation	Completed
Abdominal Aortic Aneurysm	Men, once 65-75 who smoked	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Chlamydia screen (urine)	Women, yearly if sexually active >age 24	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Cholesterol/HDL screen	All, q 5 years	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Colon Cancer screen	All, q 10 years starting age 50	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Diabetes screen	All, q 3 years	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Hepatitis C screen	All, once if born between 1945-1965	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Lung Cancer screen	All, once age 55-74, smoking hx	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Mammography	Women, q 1-2 years >age 40	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Osteoporosis	All, once >age 65	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Pap/Pelvic	Women, q 3-5 years >age 21	☐ Up to date, date _____ ☐ Due ☐ Not Applicable

Immunizations

Immunization	Recommendation	Date
Influenza	All, yearly	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Pneumonococcus 23	All >age 65, with risk <age 65	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Shingles	All, once >age 65	☐ Up to date, date _____ ☐ Due ☐ Not Applicable
Tdap	All, q 10 years, & with each pregnancy	☐ Up to date, date _____ ☐ Due ☐ Not Applicable

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Name: _____ Date of Birth: _____

Personal Medical History

☐ Check this box if you have no history of significant medical illness.

Condition	Now	Past	Comments
Alcohol/Drug Abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis			☐ Osteoarthritis ☐ Rheumatoid
Asthma			
Bladder/Kidney Problems			
Blood Clot			☐ Leg ☐ Lung
Blood Transfusion			
Breast Lump (benign)			
Cancer			☐ Breast ☐ Colon ☐ Ovarian ☐ Prostate
Cataracts			☐ Both ☐ Left ☐ Right
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes			☐ Adult Onset ☐ Childhood Onset
Diverticulitis			
Emphysema (COPD)			
Fractures (broken bones)			Location:_____
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			☐ Endometriosis ☐ Fibroids ☐ Other _____
Heart Attack			
Hepatitis			☐ Type A ☐ Type B ☐ Type C ☐ Other
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate			☐ Enlargement ☐ Nodules
Seizure/Epilepsy			
Skin Condition			☐ Eczema ☐ Psoriasis ☐ Abnormal Moles
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid Problem			☐ Hyperthyroidism ☐ Hypothyroidism
Other (specify)			

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Name: _____ Date of Birth: _____

Surgical and Procedural History

☐ Check this box if you have no history of surgeries or other listed procedures.

Surgical Procedure	Yes	Year	Comments
Abdominal surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back surgery			
Biopsy			Location: _____
Breast Biopsy			☐ Both ☐ Left ☐ Right
Breast surgery			☐ Both ☐ Left ☐ Right
Cataract surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (stomach Endoscopy)			
Gallbladder Removal			☐ Laparoscopic
Heart Surgery (other than bypass)			
Hip surgery			☐ Both ☐ Left ☐ Right
Hysterectomy (partial – ovaries left)			☐ Abdominal ☐ Laparoscopic ☐ Vaginal
Hysterectomy (total – including ovaries)			☐ Abdominal ☐ Laparoscopic ☐ Vaginal
Knee surgery			☐ Both ☐ Left ☐ Right
LEEP (Cervix surgery)			
Neck (Spine) surgery			
Ovary removal			☐ Both ☐ Left ☐ Right
Pulmonary Function test			
Sigmoidoscopy			
Sinus surgery			
Stress Test (stress echo)			
Stress Test (thallium/perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other (specify)			

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Name: _____ Date of Birth: _____

Family History

☐ Check this box if you were adopted and do not know your family history. You may skip this section.

Please indicate which relative has had the following diseases. Write the number of siblings in the boxes. If some siblings are alive and some are deceased, use the space to the right to explain.

Family Members	Mother	Father	Sister(s)	Brother(s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather		
Alive										
Deceased										
Age Currently or at Death										
Conditions & Diseases	**Mother**	**Father**	**Sister(s)**	**Brother(s)**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Other blood relatives (list relationship to you)**	**List age(s) at diagnosis & if it was cause of death**
No Significant History Known										
Alcoholism										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Breast										
Cancer, Colon										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Prostate										
Cancer, Other Type										
Colon Polyp										
Depression										
Diabetes Type I (childhood onset)										
Diabetes Type II (adult onset)										
Drug Abuse										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Attack, Angina (Coronary Artery Disease)										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
Hip Fracture										
Hyperlipidemia – High Cholesterol										
Hypertension – High Blood Pressure										
Hypothyroidism/Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Osteoporosis										
Stroke										
Sudden Cardiac Death										

Name: _____ Date of Birth: _____

Current Personal Health

Tobacco Use

☐ Never smoker ☐ Former Smoker ☐ Current everyday smoker
☐ Light tobacco smoker (<10/day) ☐ Current some days smoker ☐ Heavy Tobacco smoker (>10/day)
☐ Smoker status unknown ☐ Unknown if ever smoked

Uses/Used

☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Second Hand ☐ Electronic Cigarette ☐ Vape
☐ Unknown

Approximately how much per day
☐ Less than 1 pack a day ☐ 1 pack a day ☐ More than 1 pack a day ☐ Occasional ☐ Other
Tins per day Chewed: _____
Tins per week: _____
Cigars per day: _____
Years of smoking/exposure: _____
If former smoker, when did you quit: ☐ Less than 1 year ago ☐ More than 1 year ago
☐ Ready to quit

Sexual Activity

Sexually assaulted or abused
☐ Yes ☐ No
Sexually active
☐ Yes ☐ No
Sexual Partner (s)
☐ Men ☐ Women ☐ Both
Birth control or STD prevention
☐ None ☐ Condom ☐ Pill ☐ IUD ☐ Shot ☐ Patch ☐ Ring ☐ Diaphragm ☐ Vasectomy
☐ Tubal Ligation ☐ Other

Living Situation

What is your living situation today?
☐ I have a steady place to live ☐ I have a place to live, but am worried about losing it in the future
☐ I do not have a steady place to live
Problems with your current living situation
☐ Pests, such as bugs, ants, mice ☐ Mold ☐ Lead paint or pipes ☐ Lake of heat
☐ Oven or stove not working ☐ Smoke detectors missing or not working ☐ Water leaks
☐ None of the above

Name: _____ Date of Birth: _____

Current Personal Health

Food
Worried food would run out before able to buy more
☐ Often true ☐ Sometimes true ☐ Never true
Food didn't last and no money to get more
☐ Often true ☐ Sometimes true ☐ Never true

Transportation
Lack of transport kept you from doing things
☐ Yes ☐ No

Utilities
Utilities in danger of being shut off
☐ Yes ☐ No ☐ Already shut off

Safety (including family & friends)
How often do others physically hurt you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently
How often do others insult/talk down to you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently
How often have others threatened you with harm?
☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently
How often do others scream or curse at you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

Financial Strain
How hard is it to pay basics like food, housing, medical care, and heat?
☐ Very hard ☐ Somewhat hard ☐ Not hard at all

Family and Community Support
Do you get help with ADLS if needed?
☐ I do not need any help ☐ I get all the help I need ☐ I could use a little more help
☐ I need a lot more help
Do you feel lonely/isolated from those around you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Employment
Do you want help finding or keeping work or a job?
☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help

Name: _____ Date of Birth: _____

Current Personal Health

Socioeconomics

Do you speak a language other than English at home: ☐ Yes ☐ No If yes, what language_____

Education: ☐ High School/GED ☐ Trade School ☐ College ☐ Graduate School
☐ Other: _____

Occupation: ☐ Full Time ☐ Part Time Field of work: _____

If not currently employed, are you: ☐ Disabled ☐ Homemaker ☐ Leave of Absence
☐ Retired ☐ Unemployed ☐ Other: _____

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Partner ☐ Single

Number of Children: _____ Age(s) if minors: _____

Physical Activity

Days per week you engage in moderate exercise

Please Circle: 1 2 3 4 5 6 7

How many minutes spent exercising at moderate level

Please Circle: 0 10 20 30 40 50 60 90 120 150 or greater

Number of minutes of exercise per week: _____

Substance Abuse (past 12 months)

5 or more drinks daily (Male) 4 or more drinks daily (Female)

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost daily

Used prescription drugs for non-medical reasons

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Used illegal drugs

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

☐ Never used recreational drugs

Previous User: Names of drugs used _____

Current User: Names of drugs used _____

Safety

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things? ☐ Yes ☐ No

Have you been feeling down, depressed or hopeless in the past 2 weeks? ☐ Yes ☐ No

Feeling nervous, anxious, or on edge? ☐ Yes ☐ No

Not able to stop or control worrying? ☐ Yes ☐ No

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Name: _____ Date of Birth: _____

Current Personal Health

Female reproductive history

Age of Menarche: _____

Duration of menses: ☐ <3 days ☐ 3-5 days ☐ 6-7 days ☐ 8-10 days ☐ > 10 days ☐ Other:_____

Is the last menstrual period known? ☐ Yes ☐ No If yes, when:_____

Birth Control Method: ☐ None ☐ Pills ☐ IUD ☐ Patch ☐ Condom ☐ Vaginal Ring ☐ Implanted
☐ Sponge ☐ Cervical cap ☐ Progesterone Injection ☐ Progestin IUD ☐ Copper IUD ☐ Diaphragm
☐ Natural Family Planning ☐ Abstinence ☐ Other

History of pregnancy: ☐ Yes ☐ No

Number of pregnancies: _____

Full Term: _____

Premature: _____

Elective Abortions: _____

Multiple Births: _____

Ectopic Pregnancy: _____

Miscarriage: _____

Postmenopausal: ☐ Yes ☐ No If yes: ☐ Natural ☐ Surgical

Date of Menopause: _____

Additional Information

Medical Forms

Please check any of the following forms your have completed:

- ☐ Advance Directive for Health Care (ADHC)
- ☐ Durable Power of Attorney (DPA) for healthcare decisions
- ☐ Living Will

Social Information

Name you prefer we use when contacting you (nickname, first name, Mr., Mrs., Ms., with last name, etc): _____

I live with: ☐ Alone ☐ Spouse/Partner ☐ Children: _____
☐ Pet(s) (type): _____ ☐ Other: _____

Name: _____ Date of Birth: _____

Additional Information

Functional/ Safety Screening

☐ I am hearing impaired
☐ I am vision impaired

I need help with the following:
☐ Housework ☐ Laundry ☐ Managing Money
☐ Medications ☐ Phone ☐ Preparing Meals
☐ Transportation ☐ Other: _____

I have the following home safety concerns:
☐ Grab bars in the bathroom ☐ Handrails on stairs ☐ Lighting ☐ Rugs and Carpets

Signature(s)

I certify that the information provided is true to the best of my knowledge and understanding.

Patient Signature: _____ Time: _____ Date: _____
Guardian Signature (where required): _____ Time: _____ Date: _____

Eaton Rapids Medical Center

Date:
Name:
Date of Birth:
Medical Record #:

CONSENT FOR TREATMENT & FINANCIAL AUTHORIZATION

1. **Consent to Treatment:** I understand that I have a condition requiring treatment and do hereby voluntarily consent to such routine diagnostic procedures, hospital care and medical treatment **including but not limited to the administration of drugs, routine therapeutics, sutures and laceration repair** as deemed necessary or advisable by the physicians who treat me, their assistants or designees and hospital employees.

   I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I understand that Eaton Rapids Medical Center will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Eaton Rapids Medical Center Policy. I understand that the above-mentioned images will become part of my medical record and are subject to the same rules and regulations as any other portion of the medical record.

   I understand that I have the right to consent or refuse to consent to any proposed procedure or therapeutic course during my episode of care.

   I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.

   I understand that the physicians at this hospital may not be employees or agents of the hospital, but rather may be independent contractors who have been hired to provide medical treatment. Further, I realize that among those who may attend me at this hospital are medical, nursing and other health care personnel in training who, unless requested otherwise, may participate in patient care as a part of their education.

   I agree that specimens of blood, urine and other bodily fluids, tissues or products may be taken and that routine diagnostic tests may be performed on these specimens per the physician's order. I understand that in rare instances a person-to-person exposure may occur. If another person has a percutaneous, mucous membrane, open wound or other exposure to my blood or other body fluids, the hospital may perform, but not be limited to, the following tests: an HIV, hepatitis screens and other bloodborne pathogen tests as needed, without any additional consent. **NOTICE: The hospital may perform an HIV test upon me without any additional written consent, as stated in ACT 488 P.A. 1988, if a health professional or employee at the hospital has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids.**

2. **Authorization to Release Information:** I recognize that the Hospital may release information from my medical record including: information about communicable diseases and serious communicable diseases and infections as defined by statute and Michigan Department of Public Health rules (which include Venereal Disease, Tuberculosis, Hepatitis B, Human Immunodeficiency virus, Acquired Immunodeficiency Syndrome, and AIDS-related complex); substance abuse treatment information protected by 42 Code of Federal Regulations Part 2; psychological and social services information including communications made by me to a psychologist or social worker to:

   a) any third party payor, or insurance company or other individual who may be responsible in whole or in part for paying my hospital bill so that the Hospital may be paid for its services: and any independent auditors/reviewers retained by any third party payor, private health insurers or any employer providing health insurance benefits to me so that these independent auditors can analyze Hospital charges as is necessary to obtain payment for the services and required review or audit of that payment by the payor.
   b) any health care facility or physician to which I am referred for continuity of care.

   With respect to substance abuse information (if any), this consent may be revoked at any time, unless the Hospital has already released information in reliance upon it, or if payment for services rendered would by interrupted by such revocation.

3. **Statement to Permit Payment:** I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me by the Hospital for application to my bill. I assume full financial responsibility for payment of all expenses associated with my care and treatment, including any portion of hospital or physician charges not paid by insurance, workers' compensation or social service agencies, and agree to pay the same. These expenses may include but are not limited to daily charges for a patient-requested private room or any deductible and coinsurance amounts. I hereby certify that information given by me in applying for payment under Title XVIII Social Security Act is correct.

   I have disclosed to Hospital personnel all sources of health insurance available at the time of my admission for coverage of health care services rendered to me. Such sources of health insurance may include benefits from workers' compensation, automobile medical or a no-fault insurance program, or any liability insurance policy or plan.

   I further allow ERMC's Third Party Agency to contact me to initiate the application process regarding qualifying for Michigan Medicaid and/or Disability benefits.

Eaton Rapids Medical Center

Date:
Name:
Date of Birth:
Medical Record #:

4. **Statement to Permit Contact:** If at any time I, or a person I am responsible for, provide contact information (a wireless or landline telephone number, address, email) at which I may be contacted, I consent to receive communication in any manner, including but not limited to; automated emails, voice mails, written statements, texts, autodialed calls and pre-recorded messages, which could result in charges to me. I understand that this healthcare provider may pass this right on to its successors, and assigns, affiliates, agents and independent contractor, including but not limited to servicers and collection agents. This contact information may be used for treatment, payment and operations. I acknowledge that if I provided contact information that is owned by a third party, that I have their permission to use their contact information. I understand that is my responsibility to update this healthcare provider with new and updated contact information and that if I fail to update this information, I will hold the healthcare provider harmless for untimely notifications.

5. **Consent for Serial Treatment:** I, the undersigned patient (or individual acting on behalf of the patient), hereby voluntarily and knowingly consent to and request serial tests and/or treatments. This present consent gives my permission for the full number of serial tests and/or treatments deemed appropriate by my physician. Any additional test and/or treatment that alter this serial treatment require a new consent authorization to be completed.

   ☐ **This consent expires one year from the dated signature and may be revoked anytime with proper notification.**

6. **Release of Responsibility for Personal Valuables:** I relieve the Hospital of all liability for loss or injuries to personal property not identified and designated to the staff for safekeeping. I understand that I may request the Hospital to secure my valuables. I understand the maximum monetary recovery for the hospital in the event of loss or theft is the lesser of (1) cash value of the secured item or (2) a maximum cash recovery of $200.00. Valuables secured in the hospitals safe can only be retrieved during regular business hours.

   I further understand that the hospital is **NOT** responsible for personal items including but not limited to bridgework, dentures, hearing devices, eyeglasses, canes, walkers, clothing or like items retained in my possession while in the Hospital.

7. **Patient Self Determination: (**Please check appropriate box)

   ☐ I have received written information about Advanced Directives.

   ☐ I do not wish to receive information about Advanced Directives. ☐ Declined due to cultural or spiritual reasons

   ☐ Advanced Directives form received ☐ in medical record ☐ will bring by whom_____.

8. **Important Message from Medicare [Champus]:**

   ☐ If I possess Medicare [Champus] coverage, I have received a copy of "An Important Message from Medicare [Champus]."

9. **Medicaid Readmission Statement:** ☐ I have ☐ have <u>not</u> been an inpatient in any hospital in the last 16 calendar days.

10. **Patient Rights & Responsibilities Information:**

Notice of Privacy Practices:	☐ Received today	☐ Previously received	☐ Refused	
Health Information Exchange:	☐ Received today	☐ Previously received	☐ Refused	
Patient/Visitor Rights:	☐ Received today	☐ Previously received	☐ Refused	

11. **Type of Consent if Unable to Sign:**

    ☐ Express Consent (Signed with X) ☐ Patient is a Minor ☐ Telephone Consent ☐ Verbal Consent

    Comment: _____

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I AM SATISFIED THAT I UNDERSTAND ITS CONTENT AND SIGNIFICANCE.

_____ _____ _____

Date **Time** **Signature**

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **DPOA** ☐ **Parent/Legal Guardian** ☐ **Other:** _____

_____ _____ _____

Date **Time** **Witness**