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
Family Practice & Redicare
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

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

Springport Medical Clinic
Eaton Rapids Medical Center

# Pediatric Health History Form

**CHILD'S NAME:** _____ **DATE OF BIRTH:** _____ **AGE:** _____

**CHILD'S PREVIOUS DOCTOR/PCP:** _____

## BIRTH AND PREGNANCY

What city was your child born in? _____

Name of hospital: _____

Is this your child by: Birth Adoption Step-child Other: _____

Birth weight: _____

Was your baby premature? Y / N _____

Were there any significant medical problems during your pregnancy? Y / N _____

Were there any significant complications during labor or the baby's newborn period? Y / N _____

**If yes**, to any of the above questions, please explain: _____

_____

_____

_____

_____

## MEDICATIONS AND ALLERGIES

Please list allergies or reactions to medications, vaccines or foods

| Allergy | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please list current medications, vitamins, and supplements, even those used intermittently.

## GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development?

(Speech/language, social skills, motor skills, etc.)? Y / N _____

**If yes**, please explain: _____

_____

_____

_____

_____

**Girls only:**

Age at first period: _____

## IMMUNIZATIONS

*Please bring your child's immunization records to your appointment*

Up to date on vaccinations? Y / N _____

On a delayed plan for vaccinations? Y / N _____

Have you ever refused vaccines for your child? Y / N _____

Do you plan to refuse any vaccines? Y / N _____

**If yes**, please explain: _____

_____

_____

_____

_____

## SOCIAL HISTORY:

Smoking Status: Current Previous Never

Does anyone in household smoke? Y / N _____

Drug Use in home? Y / N _____

Soda/Coffee use? Y / N _____ Amount everyday: _____

Exercise 2+ times a week? Y / N _____

Sexually active? Y / N _____

Sexually assaulted/abused? Y / N _____

Use seatbelt? Y / N _____

Use helmet? Y / N _____

Tattoos? Y / N _____

Hurt, threatened or bullied in past year? Y / N _____

Are your child's parents: Married Unmarried Separated Divorced

Child-care situation: Parents Others (specify who and hours per day) _____

Is violence at home a concern? Y / N _____

Are there guns in the home? Y / N _____

Are there pets in the home? Y / N _____

## SPECIFIC PAST MEDICAL HISTORY

Has your child:

Had a positive tuberculosis skin test? Y / N _____

Had broken bones/frequent or severe sprains? Y / N _____

Ever used an inhaler or nebulizer? Y / N _____

Had surgery? Y / N _____

Been hospitalized overnight? Y / N Year and Date: _____

## PERSONAL/ FAMILY HISTORY:

Adopted? □ Yes □ No. If adopted and you do not know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

| **Family Members** | Patient | Mother | Father | Sister(s) | Brother(s) | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | |
|---|---|---|---|---|---|---|---|---|---|---|
| Alive | | | | | | | | | | |
| Deceased | | | | | | | | | | |
| Age Currently or at Death | | | | | | | | | | |
| **Diseases & Conditions** | Patient | 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 known and if it was the cause of death** |
| Alcoholism | | | | | | | | | | | |
| Anemia | | | | | | | | | | | |
| Asthma/ Wheezing | | | | | | | | | | | |
| Autism | | | | | | | | | | | |
| Autoimmune Disorder | | | | | | | | | | | |
| Birth Defect/Congenital Anomaly | | | | | | | | | | | |
| Bleeding Problem | | | | | | | | | | | |
| Cancer, Breast | | | | | | | | | | | |
| Cancer: Please Specify Type _____ | | | | | | | | | | | |
| Cancer: Please Specify Type _____ | | | | | | | | | | | |
| Depression | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Eczema (Atopic Dermatitis) | | | | | | | | | | | |
| Food Allergy | | | | | | | | | | | |
| Genetic Disorder | | | | | | | | | | | |
| Hay Fever (Allergic Rhinitis) | | | | | | | | | | | |
| Hearing Disorder | | | | | | | | | | | |
| Heart Attack/Coronary Artery Disease | | | | | | | | | | | |
| High Cholesterol (Hyperlipidemia) | | | | | | | | | | | |
| High Blood Pressure (Hypertension) | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | |
| Inflammatory Bowel Disease (Crohns /UC) | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | |
| Mental Retardation or Learning Disability | | | | | | | | | | | |
| Migraine Headaches | | | | | | | | | | | |
| Psychiatric/Mental Illness | | | | | | | | | | | |
| Scoliosis | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Substance Abuse | | | | | | | | | | | |
| Thyroid Disorders | | | | | | | | | | | |
| Tobacco Use | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | |
| Death before age 56 or reasons not listed above | | | | | | | | | | | |

Any other conditions you want us to be aware of for your child or family? Y / N

**If yes,** please explain:_____

Eaton Rapids Medical Center

# Treatment Consent for Minor Child or Patient with Guardianship

| Patient's Name: | Date of Birth: | Sex: |
|---|---|---|
| Street Address: | City & State: | Zip Code: |
| Phone: | Allergies: | |

| Parent/Legal Guardian 1: | Relationship: | Phone: | Alt. Phone: |
|---|---|---|---|
| Street Address: | City & State: | | Zip Code: |
| Parent/Legal Guardian 2: | Relationship: | Phone: | Alt. Phone: |
| Street Address: | City & State: | | Zip Code: |

**Copy of parent(s) or legal guardian(s) Photo ID and/or Insurance Card(s)**

Photo ID or Insurance Card Copy

Photo ID or Insurance Card Copy

I/we, as parent(s) or legal guardian(s) of the minor/patient named above, authorize the person(s) listed below to consent to diagnostic evaluation and/or treatment and emergency medical services when I am not able to accompany my child/patient. I/we understand that we can revoke this consent at any time. A facsimile or photocopy of this document will be accepted in lieu of the original. This consent is valid for one year from the signed date of this form.

Names of individual(s) authorized to acquire routine and emergency services for my child/patient:

| Full Name | Relationship |
|---|---|
| | |
| | |

| Parent/Legal Guardian Signature: | Date: |
|---|---|
| Parent/Legal Guardian Signature: | Date: |
| Witness: | Date: |
| Witness Printed Name: | Witness Phone: |
| Witness Street Address: | |

Eaton Rapids Medical Center

# PATIENT AUTHORIZATION FOR PROXY ACCESS TO PATIENT PORTAL

*(Patient MRN)*_____ (*Date request made)* _____

- **I** _____
  ***Full name of patient*** ***Date of birth***
- **AUTHORIZE**:

_____
***Proxy name*** ***Date of birth*** ***Relationship to patient***

- **To participate in Eaton Rapids Medical Center's *MyERMC* Patient Portal as my proxy**

- **Select and complete one of the following to fulfill authorization:**

❒ **My Authorized Proxy is enrolled in a *MyERMC* Patient Portal**

- *I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information through their own MyERMC Patient Portal.*

❒ **My Authorized Proxy is <u>NOT</u> enrolled in a *MyERMC* Patient Portal**

- *I understand I am requesting Eaton Rapids Medical Center to give access to my authorized proxy to utilize MyERMC Patient Portal to access my medical records. I understand that the email address, street address and phone number in the boxed section below is for the purpose of allowing my proxy to enroll in MyERMC Patient Portal and must be filled out by my above-named proxy.*

**<u>Acknowledgement of Proxy for enrollment in the *MyERMC* Patient Portal</u> *Only required for second option***

- Proxy Email Address:_____
- Address:_____
  *Street* *City* *State* *Zip Code*
- Phone Number:_____
- Proxy Signature:_____Date:_____
  - *By signing above I give Eaton Rapids Medical Center the authority to begin the enrollment process to MyERMC on my behalf. I understand that an email will be generated to the above email address with a onetime user I.D. and password which will be used to finalize the enrollment process.* *****Must Provide State Identification Card for Proof of Identity*****

- **By signing this authorization I understand:**
  - *My proxy will be able to view portions of my medical record.*
  - *Additional information may be made available to my proxy through the patient portal as Eaton Rapids Medical Center continues to implement this product.*
  - *Eaton Rapids Medical Center will require my proxy to sign an acknowledgment and agree to Eaton Rapids Medical Center's policies and procedures for the use of the patient portal if not already signed though ownership of existing MyERMC Patient portal.*
  - *This authorization is made in accordance with federal and state law and is valid until revoked by me.*
  - *I may revoke this authorization at any time by sending a written revocation to Eaton Rapids Medical Center except to the extent for uses and /or disclosures already made in reliance upon this authorization.*
  - *That once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal or state law.*
  - *A facsimile or photocopy of this document will be accepted in lieu of the original.*

_____
*Patient Signature or Legal Guardian/Representative* *Date* *Relationship to Patient*

**Identified patient by:** ❒Photo identification ❒Matching signature ❒Personally known
***Option 2 only* Identified proxy by:** ❒Photo identification ❒Matching signature ❒Personally known

_____
*Witness Signature* *Date* *Witness Printed Name*

***Section reserved for office/hospital use only***

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**