



Trinity Health

**IHA Medical Group**

# Welcome!

We are pleased that you have chosen our practice for your healthcare needs. Caring for you is our privilege. Enclosed are several informational items that will acquaint you with the practice and provide useful information about your care with us. We encourage you to take a few minutes to look through the information provided. If you have any questions or concerns, please feel free to call a member of our staff at the main practice phone number. Please refer to the enclosed practice brochure for location information. Additionally, our website has been designed to assist patients with frequently asked questions and directions to our locations. Visit us at [IHAcare.com](http://IHAcare.com).

In preparation for your appointment, please:

- complete the enclosed new patient forms located on the right-hand side of your packet.
- be sure to bring the listed items to your appointment, outlined in this packet.
- plan to arrive to your appointment 15 minutes early, in order to complete the patient registration process.

Please note that minor children (under 18 years of age) must be accompanied by a parent, or legal guardian, for most services, unless we have written consent on file. If you wish to have a minor consent on file, please complete the enclosed form and bring it with you to your appointment.

We accept most common insurance plans. We are happy to submit the claim to participating insurance companies. If we do not participate with your carrier, or your services are not covered, you will be responsible for your balance at the time of service. Please understand your coverage prior to your visit. If you have any billing questions, our reception staff will be happy to assist you.

Again, thank you for choosing IHA Medical group. We look forward to providing you with superior care and service. Please contact our office if you have any further questions prior to your appointment.

Sincerely,

IHA Medical Group Providers & Staff



## Missed Appointment Policy

Dear Patient,

We strive to create as many appointments as possible for our physicians and nurse practitioners so that we can provide all the services needed by our patients. We need the help of our patients to make our system work. We know and understand how busy everyone's lives are and we know plans change. We would like the courtesy of a call if an appointment cannot be kept.

It is our policy that any scheduled appointment be canceled with **at least 24 hours** notice to the appointment time except in the case of an unforeseen emergency.

If an appointment is canceled, we will do our best to give our patient the next available appointment time for the type of visit required.

If you fail to keep an appointment, our office will send a letter notifying you of the missed appointment and the missed appointment will be noted in your chart. There will be no charge for one missed appointment. However, in the event of a second and third missed appointment or late notice of cancel, there will be a charge of \$39. Three missed appointments may cause dismissal from our practice.

Please understand this policy will not affect those patients who keep their appointments. In an office with many missed appointments we are trying to accommodate those patients that need to be seen in our office. We look forward to your anticipated understanding and cooperation.

Sincerely,

IHA Medical Group Providers & Staff

## Patient Financial Obligations

IHA is dedicated to providing the best possible care and service to our patients in a cost-effective manner. We regard the patient's prompt handling of their financial responsibility as essential to ensure that we can provide quality services. In order to accomplish this, we depend upon prompt payment for the services we provide. To reduce any misunderstanding or confusion, we have adopted the following policy.

### Payment options if you have insurance:

IHA has made prior arrangements with most insurance companies and health plans to accept assignment of benefits. We will file a claim with all insurance companies we participate with. Please be advised that unreported changes in medical insurance could result in billing delays, rejections and personal responsibility for the services provided.

### Financial Responsibilities:

- A. You will need to pay your deductible, co-pay and any determined out-of-pocket portions at the time of service.** Unpaid co-pays will be reported to your carrier since this is a requirement of your insurance plan and may affect your insurance coverage.
- B. Bring your current insurance information to each visit.** Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. **It is your responsibility to understand your insurance benefits to include deductible amounts.**
- C.** If your health plan considers the service to be a "non-covered" benefit, you will be responsible for the charges at the time of service. If we are unable to verify coverage, you will be asked to sign a waiver (written acknowledgement) that these charges may not be covered, and you will be responsible for prompt payment of all uncovered services.
- D.** You should understand that your failure to meet your financial obligations to IHA may include (but is not limited to) additional actions such as written correspondence, collection activities, reporting to outside credit bureaus and termination of your patient relationship with IHA.

### Payment options if you have no insurance:

Payment is expected on the day that treatment is rendered unless prior arrangements have been made. You can pay by cash, check, MasterCard, VISA or Discover. Alternative payment plans may be available for those patients who qualify (when made prior to your appointment). You may inquire about this with an IHA financial representative at your office.

**Patient Appointments:** We make every effort to see our patients promptly, likewise we ask that you arrive 15 minutes before your scheduled time to register and complete paperwork so that your arrival time does not impact our ability to keep our scheduled times with you or other patients. Note that patients who are sick or have a serious problem often need to be seen on the same day. The office reserves the right to charge for "missed appointments", and you should be familiar with our missed appointment policy. We ask that patients call the office promptly if you expect to be a late arrival, are unable to keep an appointment, or need to reschedule.

**Minors:** The parent(s) or guardian(s) accompanying a minor are responsible for payment. Minors must be accompanied by a parent or legal guardian to be treated. Any exception requires the parent or legal guardian to provide IHA, prior to treatment, a signed "Authorization" to provide medical treatment.

**Monthly Statement:** If you have a balance on your account, you will be billed promptly. It will show separately the patient balance due for each visit. The total amount due from you will be summarized at the bottom of the statement. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt.

**Billing Fees:** Any balances not paid upon receipt of your statement will be assessed a monthly **late charge** at the rate of 1.5% of the outstanding adjusted balance of your account. The adjusted balance is determined by taking the patient balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. Collection Fees of \$33 per transaction will be assessed for returned or NSF checks. Further collection activity and late charges can be avoided by the timely payment of your account.

**PLEASE READ THE ABOVE PATIENT OBLIGATIONS AND AGREE TO FOLLOW THIS POLICY. FURTHER, UNDERSTAND THAT FINANCIAL ASSISTANCE IS AVAILABLE TO YOU UPON REQUEST. PLEASE CONTACT AN IHA FINANCIAL ADVOCATE TO ASSIST YOU AT: (734) 997-7700.**

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.

Trinity Health Michigan (THMI) is required by the Health Insurance Portability and Accountability Act of 1996, and the Health Information Technology for Economic and Clinical Health Act (found in Title XIII of the American Recovery and Reinvestment Act of 2009) (collectively referred to as "HIPAA"), as amended from time to time, to maintain the privacy of individually identifiable patient health information (this information is "protected health information" and is referred to herein as "PHI"). We are also required to provide patients with a Notice of Privacy Practices regarding PHI. We will only use or disclose your PHI as permitted or required by applicable state law. This Notice applies to your PHI in our possession including the medical records generated by us.

THMI understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we will use and disclose your PHI.

This Notice applies to the delivery of health care by THMI and its medical staff in the main hospitals, outpatient departments, clinics, home care and hospice programs, system-owned physician practices, and pharmacies. This Notice also applies to the utilization review and quality assessment activities of THMI as a member of Trinity Health, a Catholic health care system with facilities located in multiple states throughout the United States.

## I. Permitted Use or Disclosure

**A. Treatment:** THMI will use and disclose your PHI to provide, coordinate, or manage your health care and related services to carry out treatment functions. The following are examples of how THMI will use and/or disclose your PHI:

- i. To your attending physician, consulting physician(s), and other health care providers who have a legitimate need for such information in your care and continued treatment.
- ii. To coordinate your treatment (e.g., appointment scheduling) with us and other health care providers such as name, address, employment, insurance carrier, etc.
- iii. To contact you as a reminder that you have an appointment for treatment or medical care at our facilities.
- iv. To provide you with information about treatment alternatives or other health-related benefits or services.
- v. If you are an inmate of a correctional institution or under the custody of a law enforcement officer, THMI will disclose your PHI to the correctional institution or law enforcement official.

**B. Payment:** THMI will use and disclose PHI about you for payment purposes. The following are examples of how THMI will use and/or disclose your PHI:

- i. To an insurance company, third party payer, third party administrator, health plan or other health care provider (or their duly authorized representatives) for payment purposes such as determining coverage, eligibility, pre-approval / authorization for treatment, billing, claims management, reimbursement audits, etc.
- ii. To collection agencies and other subcontractors engaged in obtaining payment for care.

**C. Health Care Operations:** THMI will use and disclose your PHI for health care operations purposes. The following are examples of how THMI will use and/or disclose your PHI:

- i. For case management, quality assurance, utilization, accounting, auditing, population-based activities relating to improving health or reducing health care costs, education, accreditation, licensing, and credentialing activities of THMI.
- ii. To consultants, accountants, auditors, attorneys, transcription companies, information technology providers, etc.

**D. Other Uses and Disclosures:** As part of treatment, payment, and health care operations, THMI may also use your PHI for the following purposes:

- i. Fundraising Activities: THMI will use and may also disclose some of your PHI to a related foundation for certain fundraising activities. For example, THMI may disclose your demographic information, your treatment dates of service, treating physician information, department of service and outcomes information to the foundation who may ask you for a monetary donation. Any fundraising communication sent to you will let you know how you can exercise your right to opt-out of receiving similar communications in the future.
- ii. Medical Research: THMI will use and disclose your PHI without your authorization to medical researchers who request it for approved medical research projects. Researchers are required to safeguard all PHI they receive.
- iii. Information and Health Promotion Activities: THMI will use and disclose some of your PHI for certain health promotion activities. For example, your name and address will be used to send you general newsletter or specific information based on your own health concerns.

**E. More Stringent State and Federal Laws:** The State law of Michigan is more stringent than HIPAA in several areas. Certain federal laws also are more stringent than HIPAA. THMI will continue to abide by these more stringent state and federal laws.

**i. More Stringent Federal Laws:** The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.

**ii. More Stringent State Laws:** State law is more stringent when the individual is entitled to greater access to records than under HIPAA. State law also is more restrictive when the records are more protected from disclosure by state law than under HIPAA. In cases where THMI provides treatment to a patient who resides in a neighboring state, THMI will abide by the more stringent applicable state law.

**F. Health Information Exchange:** THMI shares your health records electronically or otherwise with state-designated Health Information Exchange ("HIE") that exchange health records with other HIEs. THMI also uses data exchange technology (such as direct messaging services, HIPS, and provider portals) with its Electronic Health Record ("EHR") to share your health records for continuity of care and treatment. HIEs and data exchange technology also enable the sharing of your health records to improve the quality of health care services provided to you (e.g., avoiding unnecessary duplicate testing). The shared health records will include, if applicable, sensitive diagnoses such as HIV/AIDS, sexually transmitted diseases, genetic information, and mental health substance abuse, etc. HIEs and data exchange technology function as our business associate and, in acting on our behalf, they will transmit, maintain, and store your PHI for treatment, payment and health care operation purposes. HIEs and data exchange technologies are required to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of your medical information. State law may provide you rights to restrict, opt-in, or opt-out of HIE(s). For more information, please contact THMI's Privacy Officer at 734.712.3577.

## II. Permitted Use or Disclosure with an Opportunity for You to Agree or Object

**A. Family/Friends:** THMI will disclose PHI about you to a friend or family member who is involved in or paying for your medical care. You have a right to request that your PHI not be shared with some or all of your family or friends. In addition, THMI will disclose PHI about you to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status, and location.

**B. THMI Directory:** THMI may include certain information about you in a directory while you are a hospital patient at THMI. This information will include your name, location in THMI, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation. The directory information, except your religious affiliation, will be disclosed to people who ask for you by name. You have the right to request that your name not be included in THMI's directory. If you request to opt-out of the directory, we cannot inform visitors of your presence, location, or general condition.

**C. Spiritual Care:** Directory information, including your religious affiliation, will be given to a member of the clergy, even if they do not ask for you by name. Spiritual care providers are members of the health care team at Trinity Health and may be consulted upon regarding your care. You have the right to refuse services offered by the Trinity Health Spiritual Care team. You also have the right to request that your name not be given to any member of the community (non-Trinity Health affiliated) clergy.

**D. Media Reports:** THMI will release facility directory information to the media (excluding religious affiliation) if the media requests information about you using your name and after we have given you an opportunity to agree or object.

## III. Use or Disclosure Requiring Your Authorization

**A. Marketing:** Subject to certain limited exceptions, your written authorization is required in cases where THMI receives any direct or indirect financial remuneration in exchange for making the communication to you which encourages you to purchase a product or service or for a disclosure to a third party who wants to market their products or services to you.

**B. Research:** THMI will obtain your written authorization to use or disclose your PHI for research purposes when required by HIPAA.

**C. Psychotherapy Notes:** Most uses and disclosures of psychotherapy notes require your written authorization.

**D. Sale of PHI:** Subject to certain limited exceptions, disclosures that constitute a sale of PHI require your written authorization.

**E. Other Uses and Disclosures:** Any other uses or disclosures of PHI that are not described in this Notice of Privacy Practices require your written authorization. Written authorizations will let you know why we are using your PHI. You have the right to revoke an authorization at any time.

## IV. Use or Disclosure Permitted or Required by Public Policy or Law without your Authorization

**A. Law Enforcement Purposes:** THMI will disclose your PHI for law enforcement purposes as required by law, such as identifying a criminal suspect or a missing person or providing information about a crime victim or criminal conduct.



Scan here to read a digital copy.

**B. Required by Law:** THMI will disclose PHI about you when required by federal, state, or local law. Examples include disclosures in response to a court order / subpoena, mandatory state reporting (e.g., gunshot wounds, victims of child abuse or neglect), or information necessary to comply with other laws such as workers' compensation or similar laws. THMI will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies.

**C. Public Health Oversight or Safety:** THMI will use and disclose PHI to avert a serious threat to the health and safety of a person or the public. Examples include disclosures of PHI to state investigators regarding quality of care or to public health agencies regarding immunizations, communicable diseases, etc. THMI will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA regulated products or activities, including collecting and reporting adverse events, tracking, and facilitating in product recalls, etc.

**D. Coroners, Medical Examiners, Funeral Directors:** THMI will disclose your PHI to a coroner or medical examiner. For example, this will be necessary to identify a deceased person or to determine a cause of death. THMI may also disclose your medical information to funeral directors as necessary to carry out their duties.

**E. Organ Procurement:** THMI will disclose PHI to an organ procurement organization or entity for organ, eye, or tissue donation purposes.

**F. Specialized Government Functions:** THMI will disclose your PHI regarding government functions such as military, national security and intelligence activities. THMI will use or disclose PHI to the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

**G. Immunizations:** THMI will disclose proof of immunization to a school where the state or other similar law requires it prior to admitting a student.

## V. Your Health Information Rights

You have the following individual rights concerning your PHI:

**A. Right to Inspect and Copy:** Subject to certain limited exceptions, you have the right to access your PHI and to inspect and copy your PHI as long as we maintain the data.

If THMI denies your request for access to your PHI, THMI will notify you in writing with the reason for the denial. For example, you do not have the right to psychotherapy notes or to inspect the information which is subject to law prohibiting access. You may have the right to have this decision reviewed.

You also have the right to request your PHI in electronic format in cases where THMI utilizes electronic health records. You may also access information via patient portal if made available by THMI.

You will be charged a reasonable copying fee in accordance with applicable federal or state law.

**B. Right to Amend:** You have the right to amend your PHI for as long as THMI maintains the data. You must make your request for amendment of your PHI in writing to THMI, including your reason to support the requested amendment.

However, THMI will deny your request for amendment if:

- i. THMI did not create the information;
- ii. The information is not part of the designated record set;
- iii. The information would not be available for your inspection (due to its condition or nature); or
- iv. The information is accurate and complete.

If THMI denies your request for changes in your PHI, THMI will notify you in writing with the reason for the denial. THMI will also inform you of your right to submit a written statement disagreeing with the denial. You may ask that THMI include your request for amendment and the denial any time that THMI subsequently discloses the information that you wanted changed. THMI may prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal.

**C. Right to an Accounting:** You have a right to receive an accounting of the disclosures of your PHI that THMI has made, except for the following disclosures:

- i. To carry out treatment, payment, or health care operations;
- ii. To you;
- iii. To persons involved in your care;
- iv. For national security or intelligence purposes; or
- v. To correctional institutions or law enforcement officials.

You must make your request for an accounting of disclosures of your PHI in writing to THMI.

You must include the time period of the accounting, which may not be longer than 6 years. In any given 12-month period, THMI will provide you with an accounting of the disclosures of your PHI at no charge. Any additional requests for an accounting within that time period will be subject to a reasonable fee for preparing the accounting.

**D. Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your PHI to carry out treatment, payment, or health care operations functions or to prohibit such disclosure. However, THMI will consider your request but is not required to agree to the requested restrictions.

**E. Right to Request Restrictions to a Health Plan:** You have the right to request a restriction on disclosure of your PHI to a health plan (for purposes of payment or health care operations) in cases where you paid out of pocket, in full, for the items received or services rendered.

**F. Right to Confidential Communications:** You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that THMI only contact you at work or by mail.

**G. Right to Receive a Copy of this Notice:** You have the right to receive a paper copy of this Notice of Privacy Practices, upon request.

## VI. Breach of Unsecured PHI

If a breach of unsecured PHI affecting you occurs, THMI is required to notify you of the breach.

## VII. Sharing and Joint Use of Your Health Information

In the course of providing care to you and in furtherance of THMI's mission to improve the health of the community, THMI will share your PHI with other organizations as described below who have agreed to abide by the terms described below:

**A. Medical Staff.** The medical staff and THMI participate together in an organized health care arrangement to deliver health care to you at THMI. Both THMI and its medical staff have agreed to abide by the terms of this Notice with respect to PHI created or received as part of delivery of health care to you in THMI. Physicians and allied health care professionals are members of THMI's medical staff will have access to and use your PHI for treatment, payment and health care operations purposes related to your care with THMI. The THMI will disclose your PHI to the medical staff for treatment, payment, and health care operations.

**B. Membership in Trinity Health.** THMI and other members of Trinity Health participate together in an organized health care arrangement for utilization review and quality assessment activities. As a part of Trinity Health, a national Catholic health care system, THMI and other hospitals, nursing homes, and health care providers in Trinity Health share your PHI for utilization review and quality assessment activities of Trinity Health, the parent company, and its members. Members of Trinity Health also use your PHI for your treatment, payment to THMI and/or for the health care operations permitted by HIPAA with respect to our mutual patients. All members of Trinity Health have agreed to abide by the terms of this Notice with respect to PHI created or received as part of utilization review and quality assessment activities. Members of Trinity Health will abide by the terms of their own Notice of Privacy Practices in using your PHI for treatment, payment, or health care operations.

Please go to Trinity Health's websites for a listing of member organizations at <http://www.trinity-health.org/>. Or, alternatively, you can call THMI's Privacy Official to request the same.

**C. Business Associates.** THMI will share your PHI with business associates and their Subcontractors contracted to perform business functions on THMI's behalf, including Trinity Health which performs certain business functions for THMI.

**D. Your Health Care Providers and Care Coordinators.** You receive care from THMI delivered in an integrated care setting, where patients are seen by several different providers and in several care settings as part of continuity of care and coordinated care delivery. THMI shares your PHI with other health care providers and care coordinators who work together to provide treatment, obtain payment, and conduct health care operations. Your PHI is shared electronically in multiple ways with providers involved in the delivery of care and care coordination. Your PHI may be shared via a direct connection to the electronic health record system of other providers. Your PHI may be shared in a health information exchange or via technology that enables downstream providers and care coordinators to obtain your information. Your PHI may be shared via secure transmission to other providers' inboxes.

## VIII. Changes to this Notice.

THMI will abide by the terms of the Notice currently in effect. THMI reserves the right to make material changes to the terms of its Notice and to make the new Notice provisions effective for all PHI that it maintains. The new notice will be available upon request, in our office, and on our web site. You can also ask THMI for a current copy of the Notice at any time.

## IX. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with THMI's Privacy Official. All complaints must be submitted in writing directly to THMI's Privacy Official. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). **THMI assures you that you will not be retaliated against for filing any complaint.**

## X. Privacy Official – Questions / Concerns / Additional Information.

If you have any questions, concerns, or want further information regarding the issues covered by this Notice of Privacy Practice or seek additional information regarding THMI's privacy policies and procedures, please contact THMI's Privacy Officer: 5301 McAuley Dr, Ypsilanti, MI 48197, 734.712.3577.

# Patient Centered Medical Home

A Patient Centered Medical Home is health care focused on you, the patient. It is a partnership between you and your doctor. Your doctor leads a team of health care professionals committed to improving your overall health and to helping you reach your health goals. Your health team will be led by your primary care physician and may also include nurses, specialty physicians, a nutritionist, care managers and others depending on your needs. Instead of being treated for a problem here and there without making a connection between symptoms, the Patient Centered Medical Home focuses on connecting the dots and coordinating care. Do not hesitate to come to us with any questions you may have.

## Join the MyChart Patient Portal

The MyChart Patient Portal offers patients electronic access to their health care information and a way to communicate with their physician's office that is convenient, safe and secure. The MyChart Patient Portal offers secure access to many important services.

## As we move into the future, you may notice that:

- We ask you what your goals are, or what you want to do to improve your health or the health of your family member.
- We ask you to help us plan your or your child's care and let us know if you think you or they can follow the plan.
- We give you a written copy of the care plan.
- The care team members are actively involved in planning the care you receive.
- We remind you when tests are due so that you or your child receive the best quality care.
- We ask that blood tests are done before the visit so that the doctor has the results at your or your child's visit.
- We offer patients a chance to join in a special type of visit called a "group visit."

## A partnership means that we trust you to:

- Communicate openly about any symptoms or changes in your or your family member's health and well-being.



- Learn about wellness and disease prevention and make healthy decisions about you and your family's daily habits and lifestyle.
- Follow the care plan that is agreed upon – or let us know why you are not able to so that we can try to help or change the plan.
- Tell us when you or your family member see other doctors, have a change in medication(s) or have received any other tests or treatments. Please ask them to send us a report so we are well-informed.
- Learn and become familiar with the insurance that covers you and your family.
- Respect us as individuals and partners in your care.
- Give us feedback so that we can improve our services.
- Come prepared to pay your office visit fee when you are seen in the office.

*Continued* →



**Trinity Health IHA Medical Group**



IHAcares.com

### Prescription Renewals

It is important that you ask to have prescription(s) renewed at the time of your visit. Many medications may require an office visit before they can be renewed. Please keep this in mind so that you do not run out of medication(s) before the next office visit.

If you think you or your family member may run out of medication(s) before the next office visit, you may request a renewal through the MyChart Patient Portal on IHAcars.com or call the office at least 24 hours in advance. Please have the name and dosage of the medication(s) and your pharmacy information ready when you call.

### Appointments

We know that your time is valuable and we do our best to see our patients at their scheduled time. Patients are encouraged to arrive at least 15 minutes early and sign in at the front desk. This extra time allows our staff to update records prior to you seeing the provider. If you are unable to keep your or your family member's scheduled appointment, please notify us so that we may let another patient have that appointment time. Frequently missed appointments may result in a missed appointment fee.

### We are Enhancing the Way We Deliver Health Care

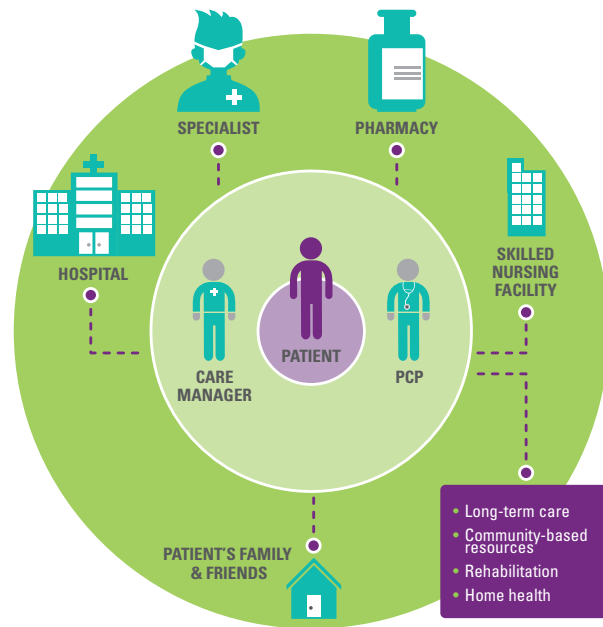
#### Patient Centered Medical Home (PCMH)

PCMH patients and their family (when appropriate) establish a partnership with their practitioners to ensure they have the support and education needed to make decisions and participate in their own health care.

### Patient Centered Medical Home - Neighborhood (PCMH-N)

PCMH-N begins with you, the patient, at the center. Your "neighborhood" consists of your primary care physician/nurses, along with specialty physicians, social workers, or other medical professionals depending on your needs. The PCMH-N team is committed to helping you reach your health care goals and improve your overall health through timely, appropriate and coordinated care.

### The Medical Neighborhood



### Trinity Health IHA Urgent Care

Our urgent care locations not only offer extended hours seven days a week including holidays, but also now offer patients the ability to **save their spot**. This allows patients to seek care at a time and location that is convenient for them. That also includes urgent care video visits in as soon as 10 minutes.

To learn more, visit: [IHAcars.com/saveyourspot](https://IHAcars.com/saveyourspot)



SCAN HERE TO SAVE YOUR SPOT!

Please visit us online for the most up-to-date hours at: [IHAcars.com/urgentcare](https://IHAcars.com/urgentcare)



Trinity Health

Trinity Health IHA Medical Group



[IHAcars.com](https://IHAcars.com)

# MyChart

## MyChart Waiting? Sign Up

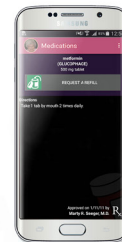
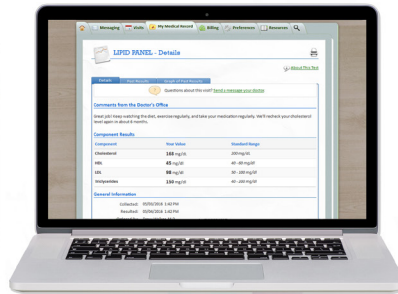
Sign up for MyChart to get the results from any tests you have today sooner! You'll also get notes from your visit right to your phone.

Ask the medical assistant to send you a registration link or type **mychart.trinity-health.org** into your phone's browser and click **Sign up now**.

Sign up today at [mychart.trinity-health.org](http://mychart.trinity-health.org)



iOS



Android



MyChart is available through any web browser at [mychart.trinity-health.org](http://mychart.trinity-health.org), or download the Trinity Health MyChart mobile app on your smart phone.

### With MyChart you can:



Manage Your Appointments



Communicate with your doctor



Online visits



Pay bills online



Access your test results



Request prescription refills

# Adult History New Patient Form

PLEASE BRING ALL MEDICATION(S) TO YOUR APPOINTMENT.

*Please complete this form and bring it with you to your visit.*

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (Last) (First) (Middle)

**Birth Sex:**  Male  Female **Current Gender Identity:**  Choose not to disclose  Female  Female-to-Male/Transgender Male  
 Undifferentiated  Genderqueer  Male  Male-to-Female/Transgender Female

**Preferred Pronoun:**  Decline to answer  He, Him, His  She, Her, Hers  They, Them, Theirs  Ze, Hir  Other \_\_\_\_\_

Single  Married  Widow(er)  Partner  Divorced **Who do you live with?**  Alone  Partner  Family  Other

Email: \_\_\_\_\_ Would you like to enroll in the Patient Portal?  Yes  No

Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

*Having race, ethnicity and language information for all of our patients helps us know them better.*

**Race:**  Alaskan Native or American Indian  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  
 White  Unknown  Other \_\_\_\_\_  Declined

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Declined

**Primary Language:**  English  Spanish  Other \_\_\_\_\_  Declined

*Are there any other languages spoken in the home? If yes, please list:*

\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Routine Check Up – No Symptoms**

**Reason for Visit:** *(please list all current symptoms)*  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

**Chronic Problems:**  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_

**Do you take your medications as directed?**  Yes  No  
*\*Please bring all medications to your visit in a bag.*

Name of Medication	Dosage	Times Per Day
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Supplements / Herbs / Over the counter medication:  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_

**Allergies:**

Source	Reaction	Source	Reaction
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

**Have you ever had any of the following?**

(If yes, enter date to those that apply)

TEST	Date
Eye Exam	_____
Dental Exam	_____
Cholesterol	_____
PPD (TB test)	_____
HIV test	_____
Hepatitis C	_____
Stool blood test	_____
Colonoscopy	_____
Bone density	_____
Chest X-Ray	_____
Heart Stress Test	_____
Blood transfusion	_____
MRI	_____
Sleep Study	_____
Other	_____

Surgical History	Date	Surgical History	Date
Angioplasty	_____	Heart Valve	_____
Appendectomy	_____	Hernia repair	_____
Arthroscopy of knee	_____	Hip/Knee replacement	_____
Back surgery	_____	Hysterectomy	_____
CABG (Heart bypass)	_____	Why did you have a hysterectomy?	_____
Carpal tunnel release	_____		
Cataract extraction	_____	<b>Was your cervix removed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Colon resection	_____	<b>Were your ovaries removed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Colostomy	_____	<b>Did you have a vaginal hysterectomy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Defibrillator	_____	LASIK	_____
Fracture	_____	Mastectomy	_____
Location: _____		Small bowel resection	_____
Gallbladder out	_____	Thyroidectomy	_____
Gastric bypass	_____	Tonsillectomy	_____
Gastric Band	_____	Pacemaker	_____
Gastric Sleeve	_____	Prostate surgery	_____
		Other	_____

Other recent physician or hospital visits:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Social History** (Check all that apply)

**Alcohol Use**  Yes  No  Former

Years Drinking \_\_\_\_\_

Drinks per week \_\_\_\_\_

Type \_\_\_\_\_

Quit date \_\_\_\_\_

Last drink \_\_\_\_\_

**Caffeine**  Yes  No Amount/week

Coffee \_\_\_\_\_

Pop/Soda \_\_\_\_\_

Energy drinks \_\_\_\_\_

Other: \_\_\_\_\_

**Exercise**  Yes  No

Frequency (Hours/week): \_\_\_\_\_

Types: \_\_\_\_\_

**Tobacco**  Yes  No  Former

Cigarettes

Packs per day \_\_\_\_\_

Cigars

Chewing Tobacco

Would like to quit

Years of use \_\_\_\_\_

Year quit \_\_\_\_\_

**Sexual History**

Are you currently sexually active?

Yes  No

Any history of sexually transmitted diseases?  Yes  No

If yes, when? \_\_\_\_\_

**Recreational drug use**

Yes  No  Former

Have you ever used IV drugs?

Yes  No

**Personal safety**

Do you wear your seatbelt?

Yes  No

Do you have difficulty dressing yourself?

Yes  No

Do you have difficulty carrying 10 pounds?

Yes  No

Do you have difficulty shopping?

Yes  No

**Other**

Have you experienced a fall in the last year?  Yes  No If yes, how many times have you fallen this year? \_\_\_\_\_

Were you injured in the fall(s)?  Yes  No

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

Little interest or pleasure in doing things  Not at all  Several days  More than half the days  Nearly daily

Feeling down, depressed or hopeless  Not at all  Several days  More than half the days  Nearly daily

Do you work?  Yes  No  Retired

Do you have a Living Will/Durable Power of Attorney?  Yes  No

How many children do you have? \_\_\_\_\_

**Personal and Family History**  Unknown/Adopted

(Check all that apply)

Circle any items that were known cause of death for relative

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
ADD/ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Alzheimer's Disease/Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Atrial fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
BPH (enlarged prostate)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Blood disease (vists to hematology)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Cancer(s):			
Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Lung	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
CVA (Stroke or TIA)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Colon problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
COPD (emphysema)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Coronary artery disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Developmental Delay	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Gall Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Gallbladder disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Glaucoma/Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hearing deficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Heart disease/problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
before age 40 (male)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
before age 50 (female)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hyperlipidemia (high cholesterol)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hypertension (high blood pressure)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Injuries:			
Concussion or head injury	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Car/motorcycle accident injury	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Ever been knocked unconscious	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Broken bones?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Which ones?			
Any other injuries:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
Irritable bowel disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Kidney stones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Learning disability	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Migraines/headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Peptic ulcer disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Peripheral vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Seizure disorder/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
OTHER (please list)			
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____

**Have you had the following illnesses or vaccines?**  
*Check all that apply*

	Date
<input type="checkbox"/> Hepatitis A	_____
<input type="checkbox"/> Hepatitis B	_____
<input type="checkbox"/> HPV (Gardasil)	_____
<input type="checkbox"/> Influenza	_____
<input type="checkbox"/> Last tetanus vaccination	_____
<input type="checkbox"/> Pneumonia (Pneumovax)	_____
<input type="checkbox"/> Pneumonia (Prevnar)	_____
<input type="checkbox"/> Shingles shot (Zostavax)	_____

**FOR WOMEN ONLY**

**How many:** Pregnancies \_\_\_\_\_ Live births \_\_\_\_\_

**Menstrual History:**  
 Age when menstrual period began \_\_\_\_\_  
 Do you use any form of birth control?  Yes  No  
 If yes, what? \_\_\_\_\_

First day of last menstrual period \_\_\_\_\_

**Screening Tests** **Date**

Last pap smear: \_\_\_\_\_  
 Any abnormal pap smears and/or cervical procedures?  
 Yes  No If yes, indicate results and date.

Mammogram: \_\_\_\_\_  
 Any abnormal mammograms?  
 Yes  No If yes, indicate results and date.





# AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Complete ALL Fields to ensure your request is processed

**Note:** You will not be contacted about the status of your requests, which can take up to thirty days to process. If you have questions, you can contact us at: 734-887-8966 or Medical\_records@ihacares.com

## AUTHORIZE AND REQUEST THE RELEASE OF INFORMATION BELOW FOR THE FOLLOWING PATIENT:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_

## RELEASE RECORDS FROM:

IHA/SMNG Provider Name: \_\_\_\_\_ Office Name: \_\_\_\_\_  
 All IHA/SJMG Provider/Offices \_\_\_\_\_  Other (Be specific) \_\_\_\_\_

## RELEASE RECORDS TO:

**Me:** I request Trinity Health to release my protected information to Myself at the address listed above.  
 **Other:** I am the legally authorized representative of the patient listed above and request Trinity Health to release the protected health information to:  
Name: \_\_\_\_\_ Company/Organization \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON:** If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at law, etc. \*BILLING: Billing information will be mailed to the address stated above unless otherwise specified.

## INFORMATION TO BE RELEASED: (Check all that apply)

Dates of service: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_  
 Office Visits  Radiology Reports  
 Outside Consult Notes  Billing Record  
 Laboratory Reports  Entire Record  
 Imaging/Films  Other: \_\_\_\_\_

## PURPOSE OF RELEASE (check reason):

Continuity of Care  Transfer out  Insurance  Legal  School  Personal  Workers Compensation

## FORMAT (Charges may apply):

Format type:  Encrypted link via Email  Encrypted CD (delivered by Mail)  Paper Copy (delivered by Mail)

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Sensitive Information:** I request the following Information be released, which may include alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS, or ARC; communicable disease or infections, including sexually transmitted disease, venereal disease, tuberculosis and hepatitis, genetic information, and demographic information, for the purposes and conditions designated on this form.  42CFR Part 2 decline to share information.

**Right to Revoke (cancelling) authorization:** I have the right to revoke (cancel) this limited authorization in writing at any time. Revocations must be made in writing and sent to Trinity Health Release of Information with the address on the top of this form. Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy or the policy itself.

**Expiration:** This authorization will expire in six months unless specified on the following date, event, or condition \_\_\_\_\_.

**Re-disclosure:** If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be re-disclosed and no longer protected by these regulations.

<b>INTERNAL USE</b>			
PRESENTED ID: <input type="checkbox"/>	PROOF OF LEGAL GUARDIANSHIP: <input type="checkbox"/>	FEE COLLECTED: <input type="checkbox"/>	WRITTEN REQUEST TO REVOKE (ATTACH) <input type="checkbox"/>
VERIFIED BY: _____	DATE RECEIVED: _____		
PROCESSED BY: _____	DATE PROCESSED: _____	FORWARDING REQUEST TO MRO FOR PROCESSING <input type="checkbox"/>	

## Physician Office Consent to Treatment

### I. CONSENT FOR MEDICAL CARE, TESTING, AND TREATMENT:

- A. I voluntarily consent to treatment which may include a complete medical history, physical examination, performance of diagnostic procedures, lab tests, x-rays, and other medical procedures as deemed necessary and appropriate by the physician, physician assistant, nurse practitioner and/or associates, including residents, students, nurses, technicians, and assistants (each a "Provider") participating in my care on behalf of [Trinity Health IHA Medical Group or Trinity Health Medical Group] ("Facility"). I understand that, absent an emergency or extraordinary circumstance, I have the right to discuss all procedures or treatments with any Provider participating in my care, and to refuse any proposed procedure or course of treatment.
- B. I am aware that the practice of medicine and surgery is not an exact science, and that results and outcomes of treatment are different for each patient. I acknowledge that no guarantees or promises have been made to me regarding my health or the results or outcomes of any procedure, test, or treatment that I authorize my Provider to perform.
- C. I authorize Facility to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.
- D. I understand that in the rare event that a Provider is exposed to my blood and/or body fluids, Facility may perform laboratory studies on my blood to detect the presence of any serious communicable diseases, such as hepatitis, HIV or AIDS. I understand Michigan law permits this testing without my consent and, should such testing occur, I will not be charged.

### II. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND RELEASE OF HEALTH RECORD INFORMATION:

- A. I acknowledge that I was offered and/or provided Facility's Notice of Privacy Practices, and that I may obtain an additional copy of the Notice at any time. This Notice describes how Facility uses and discloses protected personally identifiable information, including billing and medical information, in accordance with the protections of the law.
- B. I understand that the Facility may release my personal, billing, and medical information to other institutions, facilities, providers, payers, insurance companies or review agencies for use in connection with my current or future care, health care operations, including quality improvement and care coordination, or as required for Facility or Providers to receive payment for care. I understand and agree that this may include the following: (i) alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2; (ii) information related to HIV infection or AIDS; (iii) psychological records, social services records, and confidential communications made to a psychologist, social worker, or other provider.
- C. I understand and acknowledge that my information can be shared by Facility with other past, future, and current providers, caregivers, and facilities to coordinate my health care, for payment and for administrative purposes, including quality and care management, or as otherwise permitted or required by law. This information may include dates and services provided, location where treatment was received, treatment information, medications, diagnoses, names of physicians and other health care providers, including mental health professionals, and information related to diagnosis, care, or treatment of my mental or emotional condition.
- D. I acknowledge that my health record information may be released to my employer if this is a work-related exam or an injury for which a workers compensation claim has been filed.

### III. AUTHORIZATION FOR PAYMENT/ FINANCIAL RESPONSIBILITY

- A. I assign and authorize payment directly to Facility for all services rendered. I understand that I am financially responsible for services that may not be covered under my health insurance policy or third-party payments except where contrary to law. I understand that it is my responsibility to pay for all charges not covered by my insurance company (including deductibles and co-payments). Facility offers a financial assistance program for qualified patients who cannot pay the full portion of their bill. [Add contact #].
- B. Receiving services at a designated provider-based office is the same as receiving services from one of Facility's affiliated hospitals. I understand that separate billing may be issued for both the services of the



Facility and the services of the healthcare professionals, and that neither's charges are included in the billings of the other.

**IV. ADDITIONAL ACKNOWLEDGMENTS**

- A. **Communication Methods:** I agree that Facility and its business associates may contact me by any phone number provided by me or associated with my health record. Facility may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device. I understand that I can choose not to participate in some or all these methods by completing an opt out form.
- B. **No Tolerance for Violence. I acknowledge that Trinity Health has a "Zero Tolerance for Violence" policy.** *This applies to all patients, colleagues, volunteers, and visitors. I understand that incidents may result in removal from the facility, dismissal from the practice and potential criminal prosecution.*
- C. **Chaperone:** I understand that Facility allows for a chaperone during my visit, and I will let my Provider, or the Facility staff know if I would like a chaperone present.
- D. **Missed Appointment Policy:** I acknowledge that Facility has a missed appointment policy and that I may request the policy for review. I agree to notify the office as soon as possible if unable to keep a scheduled appointment time.
- E. **Photography or Recording:** I consent to photography or videotaping of my care and the procedures performed, including appropriate portions of my body, as the Facility or Provider determines will benefit my care, and for quality improvement, scientific research, or educational purposes, provided my identity is not revealed by the pictures or by the descriptive text accompanying them. If the photographs, or recordings identify me in any way and are used for my care, those recordings will be retained by as part of my health record
- F. **Personal Valuables:** I understand that Facility does not accept responsibility for any lost, stolen, or damaged personal items while I am at the office.
- G. **Telemedicine Services:** I understand that I may receive care through telemedicine services. Telemedicine is the use of medical and personal information exchanged between clinician and patient via electronic communications and technology to improve a patient's health status.

**THE PURPOSE OF THIS FORM WAS EXPLAINED TO ME AND I HAD THE OPPORTUNITY TO ASK QUESTIONS**

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Print Patient Full Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

---

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**If patient is a minor or adult under guardianship, parent or legal guardian must sign**

---

Signature of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

---

Print Name and Relationship to Patient. Describe authority to sign on behalf of patient \_\_\_\_\_