PATIENT INFORMATION FORM

Frankenmuth Medical Associates

Name _____ Today's Date _____

Social Security #_____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender ☐ Male ☐ Female

Home Address _____
Street City State Zip

Phone Numbers Home_____ Cell _____ Work _____

Primary Phone is ☐ Home ☐ Cell ☐ Work Reminder Call Made to ☐ Home ☐ Cell ☐ Work

Email_____ Preferred Contact Method ☐ Phone ☐ Mail ☐ Email

Preferred Language ☐ English Spanish Unknown ☐ Declined Other_____

Race ☐ American Indian/Alaskan ☐ Asian Black/African American ☐ White

☐ Native Hawaiian/ Other Pacific Islander ☐ Other Race ☐ Unknown ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

EMPLOYMENT

Employer _____ Dept./Title _____

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you

Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION

If you plan to use insurance for your medical services, you must present your current card before your visit. Otherwise, you will be asked to pay for services today and file your own insurance claim.

Primary _____ Policy # _____ Group # _____
Name of Insured & Relationship _____ DOB #_____

Secondary _____ Policy # _____ Group # _____
Name of Insured & Relationship _____ DOB #_____

PHARMACY INFORMATION

Please provide us with the local pharmacy you normally use to fill your prescriptions.

Pharmacy Name: _____

Address: _____

Phone #: _____

Assignment of Medical Beneficiary and Insurance Authorization

Frankenmuth Medical Associates

I, _____, the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby assigns and conveys directly to **Frankenmuth Medical Associates** (the "Provider"), all medical benefits and/or insurance reimbursement, if any, otherwise payable to the Patient for services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all healthcare and/or surgical benefits which the Patient is entitled to receive under the Plan, and authorizes the Provider to release all medical information necessary to process the Patient's claims thereunder.

I certify that the health insurance information that I provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card or insurance information. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and the provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for all professional services from the Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise proactively arranged with applicable PPO or ACA discount. I am fully protected against any unexpected medical bills or charges by my provider's ACA or indigency discount under the above provider's indigency Policy, for any payor compliant PPO Discount or Non-PPO Re-pricing Discount from my health insurance plan from my health insurance or plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for my ASA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment, as my authorized representative, and a PPACA or ERISA claimant, to claim or legally pursue for the proper reimbursement from my health insurance or plan.

I hereby authorize the Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I authorize the Provider, its designated business associate to make any request, file and obtain appeals information, receive any notice in connection with my appeal or health care services, wholly in my stead. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all Plan and relevant claim documents, requested disclosures, administrative claim files, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including filing, providing or receiving notice of any appeal proceedings; (5) act as my authorized representative in connection with any request for external review by applicable state or Federal External Review Process. I authorize my designated authorized representative to make any request; to present or to produce evidence; to file and obtain external review information; and to receive any notice in connection with my external review, wholly in my stead. (6) Participate in any administrative review process, including but not limited to review fiduciary duties involving the administration of benefits. I understand that I will be held financially responsible for all collection agency fees, administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law.

I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient/Guardian/Insured Signature Date

FrankenMuth Medical Associates
989-502-1122 www.frankenmuthmedical.com

Patient Centered Medical Home
Patient/Provider Agreement

Our staff is committed to providing you the highest quality medical care. Good communication between patients and providers is the key to better outcomes. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

OUR RESPONSIBILITIES TO YOU:

- **RESPECT YOU AS AN INDIVIDUAL –** We will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation or genetic information.
- **RESPECT YOUR PRIVACY –** Your medical information will not be shared with anyone else unless you give permission or as require by law.
- **PROVIDE THE BEST POSSIBLE TREATMENT AND SERVICE BASED ON CURRENT MEDICAL EVIDENCE –** We respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage.
- **MANAGE YOUR HEALTH STATUS,** including well person/preventive care as well as treatment for acute and chronic diseases. **PROVIDE YOU TIMELY ACCESS TO CARE** in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed.
- **SHARING PATIENT INFORMATION -** In the course of providing care, our providers will share patient information with other providers who are involved in the patient care as appropriate. The data may be through provision of written medical information or through electronic sharing of information.

WHAT WE ASK OF YOU:

- Ask questions, share your feelings and be part of your care.
- Be honest about your history, symptoms and other important information about your health.
- Tell your doctor about any changes in your health and well-being.
- Take your medicine as ordered and follow your doctor's advice; if you are unwilling or unable to do so, be honest with the doctor.
- Make healthy decisions about your daily habits and lifestyle.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Call your doctor first with all problems, unless you have a medical emergency.
- End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans.

PLEASE NOTE: Our office is open Monday 8am-5pm, Tuesday 8am-3pm, Wednesday 10am-7pm, Thursday 8am-5pm, Friday 8am-12pm. It is important that you keep all scheduled appointments and notify us sufficiently in advance if you need to cancel or reschedule appointments. We ask that when the office is closed, you call to talk to the on call provider for any medical issues which cannot wait until regular office hours.

URGENT OR EMERGENT CARE: Please attempt to call the on call provider before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

Patient Printed Name	Patient Signature	Date

Provider Signature	Date

Appointment/Cancellation/No Show Policy
Consent to Call/Text

Frankenmuth Medical Associates

Appointments

Office visits are by appointment only, please call 989-502-1122 to schedule. The receptionist may ask about the reason for your visit. This helps us schedule the provider's time more efficiently. Please arrive at least 15 minutes early for your appointment. Patients who are late for an appointment may be asked to reschedule at the provider's discretion. Remember to bring all of your prescriptions, over the counter medicines, vitamins and and supplements to each office visit, this will enable your doctor to review the medications at each visit.

Cancellations

When we schedule your appointment, we are reserving time for your particular needs - a room is reserved, your records are prepared, and special instruments are readied for your visit . We know that your time is valuable and, except in the case of emergency treatment for another patient you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. This courtesy makes it possible to give your reserved time to another patient who would like it. If this is not possible, please call as soon as you can so that another patient can be given your appointment time.

Missed Appointments (Non-Canceled)

We understand that missed appointments can occur for a variety of reasons, but, when you miss an appointment without canceling someone else who needed an appointment could have been seen in your place. We track missed (non-canceled) appointments. A “No Show/Late Cancellation” is defined as missing an appointment without canceling at least 24 hours before scheduled time. Your first missed visit will be waived as a courtesy, as we know emergencies happen. For each missed visit thereafter, there will be a charge of **$50 for a missed or non-canceled appointment.** Insurance will not cover charges for no show/late or late cancellation fees. Repeated missed appointments may result in your discharge from the practice. If this is the case, we will offer 30 days of emergent care only and transfer your medical records when you find a new physician.

Payment

Any copays, coinsurance, deductibles, as well as outstanding balances are due in full at the time of service **no exceptions.**

Consent to Call/Text

By providing my telephone number to Frankenmuth Medical Associates, I consent for the Practice to send automated, prerecorded, and artificial voice telephone calls and/or text messages that telephone number. To alter or revoke this consent, please notify the Practice in writing.

I understand and acknowledge the above statements:

Patient Name: _____ Date of Birth: _____

Signature of Patient/Guardian: _____ Date: _____

Notice of Privacy Practices and HIPPA Authorization

Frankenmuth Medical Associates

Patient Name:_____ Date of Birth: _____

We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. Our Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. You will be offered a copy today and it is also available on our website.

I hereby acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices:

Signature of Patient or Guardian: _____ Date:_____

HIPPA AUTHORIZATION:

I hereby authorize Frankenmuth Medical Associates to use and/or disclose protected health information (''PHI'') as indicated:

May we leave messages on your home answering machine? ☐ YES ☐ NO

May we leave messages on your work voice mail? ☐ YES ☐ NO

May we leave messages on your cell phone voicemail? ☐ YES ☐ NO

I hereby authorize Frankenmuth Medical Associates to disclose the following PHI to the individuals named below:

☐ Information regarding billing, conditions, treatment and prognosis ***INCLUDING*** records regarding mental health, communicable diseases, and drug or alcohol abuse

☐ Information regarding billing, conditions, treatment and prognosis ***WITH THE EXCEPTION OF:***

- ☐ Mental Health Records
- ☐ Communicable Diseases (including HIV/AIDS)
- ☐ Alcohol/Drug Abuse Records/Treatment
- ☐ OTHER: (please specify) _____

Spouse: Name:_____

Parent(s): Name(s):_____

Children: Name(s):_____

Other: Name:_____Relationship: _____

I understand that:

- I have the right to revoke this authorization at any time and understand that this authorization will remain in effect until revoked in writing.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- I may revoke these disclosures at any time by notifying the practice in writing. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature of Patient/Guardian: _____ Date: _____

Frankenmuth Medical Associates

Medical Records Release Form

Patient Name _____ Date of Birth: _____

Address / ***Street Number*** _____

City, State and Zip Code _____ **Phone** _____

Social Security Number / ***Last 4 digits only*** XXX - XX- _____

RECORDS REQUESTED FROM:

Name of Person or Facility _____

Practice Address / *Street Number* _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

RECORDS TO BE DISCLOSED TO:

Name of Person or Facility Frankenmuth Medical Associates

Practice Address / *Street Number* 154 S. Main Street, Suite 6

City, State and Zip Code Frankenmuth, MI 48734 Phone 989-502-1122

Fax 1 (844) 674-2260

Please select all the specific documents that apply to your request:

☐ All Notes and Consults ☐ Lab Reports ☐ Pathology Reports

☐ Hospital Records ☐ Radiology Reports ☐ Other _____

Please select the purpose of your request:

☐ Continued Patient Care ☐ Attorney/Legal ☐ Insurance ☐ Social Service/Disability

☐ Worker's Compensation ☐ Personal ☐ Other _____

Please send the records via:

☐ Mail to address above ☐ URGENT: Fax to number listed above

I understand that I may revoke this authorization any time. I understand that revocation of this authorizations will not apply to information that has already been released and that I must revoke this authorization *in writing* to Frankenmuth Medical Associates. I understand that I may refuse to sign this authorization and that my treatment cannot be conditoned upon my authorization of this disclosure. Unless otherwise revoked, this authorization will expire 1 year from the date of signature. ***My signature below confirms that I have read and understand the information in this authorization form and authorize the release of my medical records.***

_____

Patient Signature Date

_____

Printed Name of Patient

_____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

_____

Please explain Respresentative's authority to act on behalf of the Patient

Franken Muth Medical Associates

FAMILY PRACTICE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL BUT YOUR ANSWERS ARE VERY HELPFUL TO THE PROVIDER AND WILL BE KEPT STRICTLY CONFIDENTIAL.

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, i.e., vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Chickenpox	Date:	☐ Meningococcus	Date:
☐ Flu Shot	Date:	☐ MMR (Measles, Mumps, Rubella)	Date:
☐ Gardasil/HPV	Date:	☐ Pneumonia	Date:
☐ Hepatitis A	Date:	☐ Tdap (Tetanus and pertussis)	Date:
☐ Hepatitis B	Date:	☐ Tetanus	Date:
		☐ Zostavax (Shingles)	Date:

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear	Date:	☐ Abnormal	**CHECK BELOW IF APPLIES TO YOU:**
Last Mammogram	Date:	☐ Abnormal	☐ Bleeding between periods
Age of First Menstrual Period			☐ Heavy Periods
Last Period / Age of Menopause (Date / Age):			☐ Extreme Menstrual Pain
Number of pregnancies:			☐ Vaginal itching, burning, or discharge
Number of Miscarriages:			☐ Waking in the night to go to the bathroom
Number of Cesarean sections:			☐ Hot flashes
Number of Births:			☐ Breast lump or nipple discharge
Number of Abortions:			☐ Painful intercourse
Current sexual partner is:	☐ Female	☐ Male	☐ Sexually Active
Do you use condoms?	☐ Yes	☐ No	
Other Birth control method used:			
Interested in being screened for STDs:	☐ Yes	☐ No	

PAST MEDICAL HISTORY (Please check all that apply)

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Liver Disease
☐ Blood Clots	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Pulmonary Embolism
☐ Claustrophobic	☐ HIV or AIDS	☐ Reflux or Ulcers
☐ Diabetes – Insulin	☐ High Cholesterol	☐ Stroke
☐ Diabetes – Non-Insulin	☐ High Blood Pressure	☐ Tuberculosis
☐ Dialysis	☐ Overactive Thyroid	☐ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			
5.			

FAMILY HEALTH HISTORY

			SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY									
RELATION	ALIVE?	AGE	ALCOHOLISM	ARTHRITIS	DEPRESSION	CANCER	DIABETES	GENETIC DISEASE	HEART DISEASE	HYPERTENSION	OSTEOPOROSIS	STROKE
GRANDMOTHER (MATERNAL)	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GRANDFATHER (MATERNAL)	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GRANDMOTHER (PATERNAL)	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GRANDFATHER (PATERNAL)	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
FATHER	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MOTHER	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BROTHER/SISTER	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BROTHER/SISTER	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER:	☐Y ☐N		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

EDUCATION	MARITAL STATUS	EXERCISE	CAFFEINE
☐ < 8th grade ☐ High School ☐ 2 Yr College ☐ 4 Yr College ☐ Post Graduate	☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner	☐ No exercise ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # cups/cans per day? ____

ALCOHOL	TOBACCO	DRUGS
Drink Alcohol? Yes ☐ No ☐ How often? ☐ Occasionally ☐ < 3 times/week ☐ > 3 times/week # Drinks/week? ____	Do you use Tobacco? Yes ☐ No ☐ If not now, did you ever use tobacco? Yes ☐ No ☐ ☐ Cigarettes ____ pks./day ☐ Chew ____ /day ☐ Cigars ____/day # Years Used ____ Or year quit ____	Do you currently use recreational or street drugs? Yes ☐ No ☐ If yes, please list:

ADDITIONAL HEALTH FACTS

Please add other information about your health that you would like your provider to know here:

Patient, PARENT, GUARDIAN OR CAREGIVER SIGNATURE **DATE**