HASTINGS
Internal and Family Medicine

We look forward to meeting you! Please fill out the forms in this packet and return them to us prior to your appointment. If you need help, we are happy to assist you.

Your Welcome Packet includes the following forms:

- Registration form
- Contact information
- Patient-Centered Medical Home (PCMH) information
- Consent to Care Management
- Consent to Virtual appointments
- Notice of Privacy Practices
- Authorization for release of information from your previous primary provider to HIFM

At your first appointment, we will focus on building your child's health record and understanding his or her medical needs. Bring the following items to your first appointment so your time will be well spent, and to allow us to provide the best possible service!

What to bring to your first appointment

- **Medications** - All of your current medications in labeled bottles. Include all prescriptions, vitamins and supplements. Yes, we want to see the actual pills and labels!
- **Allergies list** - A list of all drug allergies and side effects that you have had.
- **Medical history** - A list of all medical problems and surgeries that you have had during your lifetime.
- **Medical records** - Copies of all medical records that you have available, including vaccination records.
- **Advance directive** - Your advance directive (living will) and Designation of Patient Advocate (medical power of attorney), if you have them.
- **Doctors' information** - The names, addresses and telephone numbers of all doctors that you have seen in the past 12 months.
- **Your questions** - A list of questions you or your child may have about their health.
- **Insurance information** - Your insurance information. We want to see your current insurance card at every appointment.

--- Thank you, from your Hastings Internal and Family Medicine team !

Pediatric Patient Registration *(requires signature)*

IMPORTANT: YOU MUST LIST ALL INSURANCES

Child's Last Name: _____ Middle Initial: _____ First Name: _____Birth date: _____

Childs Address: _____ City: _____ State: _____ Zip: _____

Social Security # _____ Gender at birth: Male Female

Gender identity: _____ Preferred pronouns: (if any) _____

Fathers Name: _____ Birth date: _____

Home phone #: _____ Cell phone #: _____

Fathers Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Employer: _____

Insurance Carrier (if child is covered under policy): _____

Insurance Contract #: _____ Group #: _____

Mothers Name: _____Birth date: _____

Home phone #: _____ Cell phone #: _____

Mothers Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Employer: _____

Insurance Carrier (if child is covered under policy): _____

Insurance Contract #: _____ Group #: _____

Legal Guardian other than Father and Mother

Name: _____ Birth date: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Other Insurance

Insurance Carrier: _____ Contract#: _____ Group #: _____

Name of Subscriber: _____ Birth date: _____ Relationship: _____

Insurance Carrier: _____ Contract #: _____ Group #: _____

Name of Subscriber: _____ Birth date: _____ Relationship: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, authorize payment of authorized insurance benefits be made on my behalf to Hastings Internal and Family Medicine for any services provided by this organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits Payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity if requested.

I understand that I am financially responsible for any charges not covered by my child's health care benefits. It is my responsibility to notify Hastings Internal and Family Medicine of any changes in my child's health care coverage.

SIGNATURE: _____ Date: _____

Printed name and relationship to the patient: _____

Pediatric Emergency Contacts and Authorizations (requires signature)

Child's Last Name: _____ First Name: _____ Birth date: _____

Emergency Contact 1: _____

Relationship: _____ Phone #: _____

Emergency Contact 2: _____

Relationship: _____ Phone #: _____

AUTHORIZATION FOR NON-PARENT TO MAKE MEDICAL DEISIONS FOR MINOR CHILD

I authorize the following person(s) to bring my child to Hastings Internal and Family Medicine and make medical decisions for their care. (Please include any step parents)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

AUTHORIZATION TO TREAT A MINOR CHILD AGE 16 OR OLDER WITHOUT PARENT OR GUARDIAN PRESENT

(For minor child age 16 or older please choose one below)

☐ **APPROVED.** When I am not here with my minor child age 16 or older the providers and staff of Hastings Internal and Family Medicine may give medications, perform procedures that are also needed for the health of my child and treat. I am aware that copays and deductibles may apply with my insurance, and that I will be responsible for the amount due.

☐ **DECLINED.** I decline to allow my minor child age 16 or older to come to appointments without a parent or guardian present.

SIGNATURE: _____ Date: _____

Printed name and relationship to the patient: _____

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the practice's Privacy Contact at: Hastings Internal and Family Medicine 225 S M37 Hwy, Suite 1 Hastings, MI 49058. I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand the above family members and/or friends may have limited access to my child's protected health information. I understand that I may revoke or change this consent at any time. I understand that it is the responsibility of the parent or guardian to maintain this list of names**. Any updates or changes require a new consent form be completed and signed by the biological parent/guardian ONLY**. I understand that the biological mother and father are always permitted to have access to my child's protected health information unless the parental rights of either the father or mother have been legally terminated.

SIGNATURE: _____ Date: _____

Printed name and relationship to the patient: _____

Patient-Centered Medical Home (requires signature)

Hastings Internal and Family Medicine is a level III NCQA certified Patient-Centered Medical Home

What is a Patient-Centered Medical Home?

A "Patient-Centered Medical Home" is a home for all of your health care needs. We serve as the center of your healthcare, coordinating all medical services no matter where they are provided. We are your home because we care about you, and will work personally with you to be as healthy as possible. And if we can't provide the service you need, we'll help you find a medical provider or specialist who can.

The Medical Home model is a team-based approach to care. The team is led by Physicians and includes Mid-level providers, Medical assistants, and Care Managers who work together with you to make sure your individual needs are met.

As a member of this medical home, you have a right to expect privacy, quality and respect. In return, we expect you to do your best to provide all necessary information, follow recommendations and live a healthy lifestyle. In this way, we believe you can achieve your best possible health.

As your Medical Home, we will:

- Treat you and your family with respect and consideration.
- Give you complete access to all of your health information.
- Provide the best possible advice and treatment based on current medical evidence.
- Help you to develop and carry out your own personal health care goals.
- Give recommendations for a healthy lifestyle.
- Provide treatment for acute illness and long term disease.
- Direct you to high quality specialists and other care providers as needed.
- Provide 24-hour access to care via the patient portal, the answering service and local Urgent Care. If needed, the emergency department can be used (for emergencies only).
- Provide same day appointments, whenever possible.
- Listen to your suggestions and work to improve our services to better meet your needs.

What we ask of you:

- Contact us ***first*** with new health care needs, unless it is a medical emergency.
- Keep all scheduled appointments.
- Carefully consider our medical recommendations including testing, treatment, vaccinations, and routine screening, and inform us if you do not agree with or will not be able to follow the recommended plan.
- Recognize the impact of your lifestyle on your personal health.
- Request additional information when you do not fully understand your condition or your provider's instructions.
- Provide all pertinent information about past illnesses, hospitalizations, medications, and other health related matters.
- Provide a copy of your advance directive and medical power of attorney, if you have one.
- Be considerate of the needs of other patients in the office and our office staff.
- Make required payments at the time of service, and provide all needed information for insurance claims.

Working together

We pledge to do our best as your healthcare provider. Despite this, there may be times when we do not fulfill your expectations. Please let us know as soon as possible if you feel we have missed something important or have failed to provide good service. While we try to do a great job, we need your help to keep our standards high.

Ending the partnership:

At times, a doctor-patient relationship may suffer from lack of mutual trust, poor communication, or failure to fulfill the terms of this agreement.

If this occurs, either the patient or the physician may choose to end the partnership, and request that further health care be obtained elsewhere. Hastings Internal and Family Medicine provides patient records for transfer of care at no charge.

I have read the above and agree to participate in the Patient-Centered Medical Home.

SIGNATURE:

_____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

Consent to Care Management (requires signature)

Care Managers are trained Registered Nurses and others who coordinate services for patients with complex and chronic conditions or life issues that impact their health. Care Managers help patients have a better health care experience, better health outcomes, and reduced expenses for medical tests and treatment.

Care Managers provide the following services:

- Help you understand and follow your medical plan of care as directed by your provider.
- Learn *your* concerns and priorities to inform your provider about what is most important to you.
- Work with you one-on-one or in a group setting to overcome barriers that prevent you from reaching your personal health goals.
- Coordinate services among medical providers such as hospitals, specialists, home care services and personal care givers and pharmacies.
- Inform you about advance directives and other important decisions that impact your future.

Care Management services are paid for by your insurance, including Medicare, Blue Cross and Priority Health. Depending on your insurance, a copay may be required. Only one medical office may deliver Care Management services for any patient at a time. You may discontinue Care Management services at any time by notifying your provider.

At Hastings Internal and Family Medicine, we believe that Care Management improves the care you receive from our practice, and will improve your health! Please ask your provider or any staff member if you have questions about Care Management services.

I understand that Hastings Internal and Family Medicine will provide me with Care Management which may include office visits, telephone visits, chart reviews, and coordination of services from other providers. I understand that my health information may be requested from and shared with other providers for care coordination purposes. I further understand that I may refuse any Care Management service at any time.

SIGNATURE:

_____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

Consent to Virtual Appointments (requires signature)

Virtual Appointments are face-to-face confidential encounters with Hastings Internal and Family Medicine providers provided through an electronic interface, such as a smart phone or web cam using encrypted software.

Virtual Appointments offer several benefits:

No need to drive in to the medical office.
Save time and money compared to regular visits.
Increased privacy as your visit can be done from your home or car.
Easier access for patients with limited mobility.

There are a few disadvantages:

Your provider can perform only a limited physical examination.
Some medical problems are not suitable for Virtual Appointments.
Not all insurances cover Virtual Appointments.

Hastings Internal and Family Medicine is obligated to provide a secure and private environment for the appointment, and to use software that is fully HIPAA compliant. It is the patient's obligation to ensure privacy on his or her end of the secure connection.

Virtual Appointments may result in specific recommendations by the provider including prescription or over-the-counter medications, lab testing or x-ray, referral to a specialist, or scheduling an in-office appointment.

Your Virtual Appointment will be permanently documented in your personal electronic health record.

It is possible that technical difficulties with the interface could interrupt the appointment. If this occurs, both the provider and the patient agree to attempt to reestablish the connection, and if this cannot be done, will reconnect by telephone.

If you have insurance coverage for virtual visits, your insurance company will be billed. If there is no coverage you will be asked to pay for the visit with a credit card at the time of the visit.

I understand the benefits and disadvantages of Virtual Appointments and agree to the terms described above. I understand that participation in Virtual Appointments is optional, and any Virtual Appointment will only be scheduled with my consent.

SIGNATURE:

_____ _____ _____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

Notice of Privacy Practices – 3 pages (requires signature)

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We use this information, often referred to as your health or medical record, as a basis for planning your care and treatment, a means to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We understand that your medical information and your health are personal and private, and we are committed to protecting all of your medical information.

We are required by law

- To make sure that medical information that identifies you is kept private.
- To give you this notice of your legal duties and privacy practices with respect to medical information about you.
- To follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you

The following describes different ways that we use and disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment – we may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, office staff, technicians, or other personnel who are involved in taking care of you. In addition, we may also disclose medical information about you to people outside of our office who may be involved in your medical care after you leave our office, such as family members or other designated caregivers who provide services that are part of your care.

For Payment – We may use and disclose medical information about you so that the treatment and services you receive at the office may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

For Health Care Operations – We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, medical students and other personnel for review and learning purposes. In order to facilitate electronic sharing of your personal health information among your healthcare providers, we participate in the POM/ACO and the Health Information Exchange. This allows your medical treatment to be based on as complete a record as possible, to reduce costs, and ensure quality.

Contacting you – We may use and disclose health information to contact you as a reminder that you have an appointment at our office and other matters. We may contact your by mail, telephone or via the patient portal. Although we will not release your information to any unauthorized third party without your permission, in the event that we are not able to contact you, our office may leave messages on your answering machine or with a family member or another individual who actively assists with your health.

Individuals Involved in Your Care or Payment for Your Care – It may be necessary for us to release medical information about you to a friend or family member who is involved in your medical care or to someone who helps pay for your care unless there is a specified written request from you to the contrary.

As Required By Law – We will disclose medical information about you when required to do so by federal, state or local law. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or other person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation – We will disclose medical information to organizations that handle organ, tissue and eye donors and transplant recipients as necessary to facilitate organ or tissue donation and transplantation, if you have requested to be an organ donor.

Military and Veterans – If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation – We may disclose medical information about your for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks – We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report the abuse or neglect of children, elders and dependent adults.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence.

Lawsuits, Disputes and Law Enforcement – We may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, unless we have a prior legally valid order prohibiting the release of such information. We may release medical information if asked to do so by law enforcement officials in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, or missing person; about the death we believe may be the result of criminal conduct; about criminal conduct at the office; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the persons who committed the crime. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Coroners, Medical Examiners and Funeral Directors – In the event of your death, we may release medical information to a coroner or medical examiner. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Protective Services for the President – We may release medical information about you to authorized federal officials for intelligence, counter intelligence and other national security activities only as required by law. We may also disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

If your personal health information is to be used for any other purpose, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures

Your Rights Regarding Medical Information about You

Right to Inspect and Copy - In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your health. If you request copies, there may be a charge for records and it may take up to 30 days to provide them. Records may be provided in either paper or electronic format.
If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to submit an amendment statement for as long as the information is kept by or for the office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to Accounting of Disclosures - You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes.

Right to Request Restrictions - You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We will consider your request but are not legally required to accept it.

Complaints
If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records you may contact the Privacy Officer listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Acknowledgement
I acknowledge receipt of this Notice of Privacy Practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

SIGNATURE:

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

If you have any questions or privacy complaints please contact:

Hastings Internal and Family Medicine Privacy Officer
225 S M-37, Suite 1, Hastings, Michigan 49058
Telephone (269) 948-0078
www.HastingsMed.com

Authorization for Release of Medical Information to Hastings Internal and Family Medicine

Patient Name | Date of Birth | Today's Date

I authorize _____
Name of Practice or Individual

_____
Address

_____
Telephone Number | Fax Number

to disclose or provide the following protected health information about me to:

Hastings Internal and Family Medicine
225 S M-37, Suite 1
Hastings, MI 49058
Fax 269-948-0099

☐ Entire patient record; (or, check only those items of the record to be disclosed below)

- ☐ Office/Consult notes
- ☐ Lab/X-ray results, pathology reports,
- ☐ Financial History
- ☐ Immunization record
- ☐ Immunization record
- ☐ Medical Summary
- ☐ Confidential record of HIV and communicable disease testing
- ☐ Confidential records of mental health or substance abuse treatment
- ☐ Only the following:_____
- ☐ Dates: _____

Purpose for release:
- ☐ Transfer of care
- ☐ Continuing care or consultation
- ☐ Request of patient or legal representative

- This release is effective for one year from the date of signature. It may be revoked at any time by providing written notice to the practice or individual listed above.
- A facsimile or photocopy of this document may be accepted in lieu of the original.
- Medical records released to Hastings Internal and Family Medicine are subject to privacy protections under the Health Insurance Accountability and Portability act, and may not be further released without specific written authorization.

_____
Signature of Patient or Legal Representative | Relationship to patient if applicable | Date

_____
Signature of Witness | Date