Family Health Care

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT & SIGNATURE FORM

Patients Name (*Please Print*): _____ **Birthdate:**_____

The Notice of Privacy Practices describes how the Facility uses and discloses your health information and the circumstances under which we must seek your written permission to do so. The Notice of Privacy Practices also describes rights you have under federal regulations called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA requires us to provide you with the Facility's Notice of Privacy Practices, and to obtain your written acknowledgment for receiving it.

By signing this form, you are acknowledging that the Facility provided you with its Notice of Privacy Practices; by signing, you are not agreeing or disagreeing with its content. If you do disagree, the Notice of Privacy Practices provides information about how you may address your concerns. By signing below, I acknowledge receiving the Facility's Notice of Privacy Practices.

(X)_____ _____
Signature of Patient or Representative Date

_____
Representative's Relationship to Patient (if applicable)

****

For Office Use Only

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: _____
Date of attempt to obtain Acknowledgment: _____
Reason Acknowledgment was not obtained: _____

****

_____ I hereby acknowledge that I have received a copy of BFHC's Mission Statement and Patient Rights and
Initial Responsibilities.

I hereby authorize BFHC and the Provider assigned, as provided by law, to furnish medical/dental/optical, office surgery or diagnostic treatment and any local anesthetic as he/she considers necessary and proper in the treatment of the patient for the purpose of correcting his/her physical condition.

_____ This authorization shall be valid until rescinded in writing or replaced by one of a later date
Initial

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Baldwin Family Health Care for any services rendered to me by them. I authorize any holder of medical/dental/optical information about me to release to the Centers for Medicaid and Medicare Services (CMS) and/or the Insurance Carrier and their Agents any information needed to determine these benefits of the benefits payable for related services. I acknowledge full responsibility for the payment of services and agree to pay for them at the time service is rendered, unless other arrangements are made.

_____ Note: Your blood may be tested for HIV or Hepatitis if an employee is exposed to your body fluids. This is in compliance
Initial with Public Act #448.

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BALDWIN FAMILY HEALTH CARE DISCLOSURE REQUEST

May we disclose health information about you to family members and friends who are involved in your care or the payment thereof?

- ☐ **Yes, you can discuss my care with any of my family members or friends that inquire about me.**
- ☐ **No, you can only disclose information to me.**
- ☐ **Yes, but only to the following individual(s):**

_____ _____ _____ _____
Name Relationship to patient Name Relationship to patient

****

(X)_____ _____
Signature Relationship, if not patient

_____ _____
Witness Date

Family Health Care

PATIENT REGISTRATION

Patient Name: _____
Prefix (Mr., Mrs.) Last Maiden (if any) First Middle Initial Suffix (Jr., Sr.) Nickname

Social Security Number: _____ **Date of Birth:** _____ **Birth Sex:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email Address:** _____

Patient's Employer: _____ **Phone #:** _____

Emergency Contact: _____ **Phone #:** _____

Appointment Reminder Contact Method: ☐ Phone ☐ Text ☐ Email

How did you hear about FHC? (Please circle one)

Billboard	Facebook / Instagram / Social Media	Google / Yahoo / Search Engine	Phonebook	Other: _____
Brochure	Family / Friends	Insurance Carrier	Post Card	
Event	Flier / Poster	Newspaper / Magazine	Website	

If patient is a minor (under the age of 18) please complete the following:

Guarantor (Person financially responsible for minor patient)

Name: _____ Relationship to Patient: _____
Last First

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Parents of Minor Patient

Mother: _____ Date of Birth: _____

Father: _____ Date of Birth: _____

Insurance Information (*Please list all applicable coverage*)

Insurance #1: _____ Contract #: _____ Group #: _____

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

Employer's Name: _____

Billing Address - *Complete for Commercial Insurance only*: _____

_____

Effective Date of Coverage: _____

Please complete side 2

Insurance #2:_____ **Contract #:**_____ **Group #:** _____

Subscriber's Name:_____ **Subscriber's Date of Birth:** _____

Employer's Name:_____

Billing Address - ***Complete for Commercial Insurance only*****:**_____

_____

Effective Date of Coverage: _____

By signing below, I authorize Baldwin Family Health Care (BFHC) and its affiliates to contact me by automated SMS text message for appointment reminders, marketing, and other information pertaining to my care. I understand that message / data rates may apply to messages sent by BFHC or its affiliates under my cell phone plan. I know that I am under no obligation to authorize BFHC or its affiliates to send me text messages. I may opt out of receiving these communications at any time by calling the office or by responding STOP to any message I receive from BFHC.

Please allow 2 - 3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date / time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from BFHC and its affiliates to the phone number that I have provided.

Signature required if requesting text message reminder

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

Family Health Care Financial Policy Summary

We will file your claim to the Insurance(s) indicated. If we are unable to successfully collect reimbursement from your carrier, FHC will seek payment from the Guarantor indicated on the reverse side of this form.

FHC supports the policy of collecting deductibles, co-pays and any other related out of pocket expenses at time of service. Patients without insurance may be eligible for reduced fee services. If you are unable to pay at the time of service, you may meet with a Financial Counselor to establish payment arrangements.

This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

I have reviewed the above statements and agree that I am responsible for any outstanding charges for all professional services provided.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

I authorize the release of any medical / dental / vision information necessary to process any claims.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

I authorize my Insurance Carrier to pay medical / dental / vision benefits directly to FHC on my behalf.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

Family Health Care

Dental Cancelled / Missed Appointment Policy

1615 Michigan Avenue
Baldwin, MI 49304
Phone: 231-745-2736
Fax: 231-745-5050

730 Water Tower Rd
Big Rapids, MI 49307
Phone: 231-527-7264
Fax: 231-796-4109

520 Cobb Street
Cadillac, MI 49601
Phone: 231-876-6505
Fax: 231-876-6799

11 North Maple
Suite 200
P.O. Box 7
Grant, MI 49327
Phone: 231-834-9750
Fax: 231-834-1459

1035 East Wilcox
P.O. Box 746
White Cloud, MI 49349
Phone: 231-689-1608
Fax: 231-689-3162

Patient Name:_____ Date of Birth: _____

Our mission is to provide quality, integrated and comprehensive health care services that are accessible to all.

Your Rights:

The Family Health Care dental staff is committed to providing quality dental care. You have the right to be informed of the examination findings and to consent or decline the recommended treatment. You have the right to considerate, respectful and confidential care. You have the right to know in advance the cost of the care that you will be provided.

Your Responsibilities:

You must provide the dental staff accurate information before, during and after treatment. It is important that you follow your dentist's advice and recommendations regarding medication, pre/post treatment instructions, referrals to the other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist you may increase the chance of a poor outcome.

We understand that occasionally circumstances arise preventing you from keeping appointments. If you find it impossible to keep an appointment, you should inform us 24 hours in advance. This will enable us to reschedule an appointment for you and also let another patient have the appointment time that had been reserved for you.

Our policy for failed appointments: (A failed or no-show appointment is considered an appointment that is cancelled less than 24 hours in advance or when a patient does not show up or call at all to cancel a scheduled appointment. Monday appointments should be cancelled the Friday before.)

- The **First** time you fail or no-show for an appointment, you will receive a letter noting that you missed an appointment. You will still be able to schedule another appointment.
- The **Second** time you fail or no-show, you will be allowed to have same day or next day appointments **if** there are any cancellations.
- If there is a **Third** no-show we will **NO LONGER** provide regular dental care for you. We will only offer you emergency treatment.
- If you ask to become an established patient with the dental center and then fail or no-show your **New Patient** exam, no other appointments will be scheduled for you for 1 year.
- If you are seen on an **Emergency** basis and the doctor would like to schedule you back to continue treatment and you fail or no-show, no future appointments will be scheduled for you for 1 year.

Thank you in advance for your cooperation.

By signing this form, I am authorizing Family Health Care to provide my dental care, to release my x-rays and other information to my insurance provider, and to bill my insurance. I also am acknowledging that I have read and understand Family Health Care's policy for failed or no-show appointments and accept the consequences if I fail to show up for my appointment.

_____ _____

Signature (Patient, parent or guardian) Date

Family Health Care

Medical and Dental History

Name:_____ DOB:_____ Gender: Male Female

Address:_____
Street City State Zip

Phone:_____ Work Phone:_____

MEDICAL HISTORY

Name of Physician:_____ Phone:_____

Physician's Address:_____

When was your last physical?_____ Are your immunizations up to date? Yes No

Are you now under the care of a physician? Yes No If yes, for what reason?_____

Are you presently taking any medications/drugs/pills? Yes No Please list:_____

_____

Which pharmacy do you prefer to use:_____ Phone:_____

Are you allergic (or have an adverse reaction) to any medication or materials?

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐ None

☐ Other ☐ Sulfa ☐ Other Antibiotic Please describe:_____

Are you sensitive or allergic to latex (I.e. experienced itching, rash or wheezing after using latex gloves or handling a balloon)? Yes No

Have you had any unusual or unexplained reactions during a dental procedure, including the anesthetic? Yes No

If yes, please explain:_____

Are you taking or have you taken any medications to treat osteoporosis, such as bisphosphonate? Yes No

If yes, please explain:_____

Do you have, or have you had any of the following: Please circle Yes or No

Abnormal Blood Pressure	Yes	No	Disruptive Behavior	Yes	No	Learning Disability	Yes	No
ADHD	Yes	No	Recreational Drugs	Yes	No	Liver Disease	Yes	No
Alcohol Addiction	Yes	No	Emphysema/COPD	Yes	No	Lung Disease	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Mental Health Treatment	Yes	No
Anorexia	Yes	No	Fainting Spells	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve	Yes	No	Fibromyalgia	Yes	No	Organ Transplant	Yes	No
Artificial Joint	Yes	No	GERD	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Hearing Impaired	Yes	No	Prolonged Bleeding	Yes	No
Autism	Yes	No	Heart Attack	Yes	No	Psychiatric Care	Yes	No
Bulimia	Yes	No	Heart Disease/Surgery	Yes	No	Radiation Therapy	Yes	No
Cancer	Yes	No	Heart Infection	Yes	No	Sickle Cell Disease	Yes	No
Chemical Dependency	Yes	No	Heart Pace Maker	Yes	No	Sinus Trouble	Yes	No
Chemotherapy	Yes	No	Hemophilia/Bleeding	Yes	No	Stroke	Yes	No
Chronic Pain	Yes	No	Hepatitis ___ A ___ B ___ C	Yes	No	Thyroid Problems	Yes	No
Congenital Heart Disease	Yes	No	HIV Positive/AIDS	Yes	No	Tuberculosis	Yes	No
Cortisone Medicine	Yes	No	Immune System Disorder	Yes	No	Tumors	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Ulcers	Yes	No

Continued on Back Side

MEDICAL HISTORY Continued

Have you had any other serious illness, hospitalization or accident? Yes No

If yes, please explain: _____

Do you currently smoke or use the following tobacco products? _____Cigarettes _____Cigars _____Pipe _____Chew _____None

Frequency: _____

Have you used tobacco products in the past? Yes No If yes, how long ago? _____

Do you drink alcoholic beverages? Yes No If yes, how much? ——————————

WOMEN: Are you pregnant? Yes No Are you nursing? Yes No Do you take birth control medications? Yes No

Do you anticipate becoming pregnant? Yes No

DENTAL HISTORY

Date of last dental visit? _____

Yes No Do your gums bleed while brushing or flossing?

Yes No Are your teeth sensitive to hot or cold liquids/foods?

Yes No Are your teeth sensitive to sweet or sour liquids/foods?

Yes No Do you feel pain to any of your teeth?

Yes No Do you have any sores or lumps in or near your mouth?

Yes No Have you had any head, neck or jaw injuries?

Yes No Do you have frequent headaches?

Yes No Do you clench or grind your teeth?

Yes No Do you bite your lips or cheeks frequently?

Yes No Have you ever experienced any of the following:

☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐ Difficulty in chewing

Yes No Have you had any orthodontic work (braces)?

Yes No Have you ever had prolonged bleeding following extractions?

Yes No Have you ever had instructions on the correct method of brushing your teeth?

Yes No Have you ever had instructions on the care of your gums?

COMMENTS _____

_____

_____

_____

_____

_____

Family Health Care

UDS Information (FQHC Letter)

Today's Date: _____

Dear Patient,

Family Health Care is designated as a Federally Qualified Health Center (FQHC). An FQHC receives additional funding from the federal government to extend medical care to uninsured/underinsured patients. One requirement of this designation is for the clinic to gather additional information about all of our patients to help determine if community medical needs are being met. In order for us to continue to serve our community, we request that you please take a moment to complete the following information:

Patient Name: _____ Date of Birth: _____

Primary Medical Insurance: _____ Medicare _____ Medicaid _____ Commercial _____ None

Family Size: _____ Family Size or Household Size is described as persons living under one roof in an interdependent relationship

Family Gross Income: $_____ ☐ Weekly ☐ Monthly ☐ Annually

Race:

____More than one race
____American Indian/Alaskan Native
____Asian
____Asian Indian
____Black/African American
____Chinese
____Filipino
____Guamanian or Chamorro
____Japanese
____Korean
____Native Hawaiian
____Other Asian
____Other Pacific Islander (not Hawaiian)
____Samoan
____Unreported/Not Reported
____Vietnamese
____White

Ethnicity:

____Not Hispanic or Latino
____Arab/Chaldean
____Chicano
____Cuban
____Hispanic or Latino
____Mexican
____Mexican American
____Puerto Rican
____Spanish
____Unknown

Please check all that apply:

____ Military Veteran
____ Dependent of Seasonal/Migrant Worker
____ Require Translation Services_____ Native Language
____Seasonal/Migrant Worker
____Primary Language other than English
____Homeless

Sexual Orientation:

____Straight ____Bisexual ____Lesbian/Gay ____Don't know ____Something else

Gender Identity:

____Male
____Female
____Transgender female/male to female
____Transgender male/female to male
____Other

Family Health Care

PATIENT-CENTERED MEDICAL AND DENTAL HOME
PATIENT RIGHTS AND RESPONSIBILITIES

Our Mission: To provide quality, integrated and comprehensive health care services that are accessible to all.

Your Rights

1. You have a right to affordable health care and to apply to our sliding fee program.
2. You have a right to know our operating hours, services available and after hour coverage.
3. You are entitled to participate in treatment decisions and receive information concerning your diagnosis, treatment and prognosis. You may refuse care or treatment, but if you refuse treatment, you may be asked to sign a written release of responsibility.
4. You have the right to privacy per HIPAA guidelines.
5. You have the right to high quality and efficient health care from your Patient-Centered Home (PCH) team of support staff and providers who are trained to meet your Medical, Dental, Behavioral Health, Pharmacy and Optometry needs.
6. You may ask the names of your PCH team caring for you and their role in your treatment.
7. You have a right to choose your healthcare provider and the right to request a change of provider under extenuating circumstances.
8. You have the right to a response to your questions and obtain your test results.
9. You have the right to know the professional experience and certification of our medical, dental, behavioral health and optometry providers, the organization accreditation status and other measures of quality.
10. In most cases, you may look at or obtain copies of your medical, dental, behavioral health and/or optometry records. A fee may be charged for copies of your records.
11. Your guardian, next of kin, or legally authorized responsible person can exercise your rights for you and/or obtain your health information only per your prior written consent.
12. You will be notified in advance whenever practical if your provider cannot keep an appointment.
13. You have the right to voice a grievance with the Site Facility Manager if you are dissatisfied with your care or treatment.
14. You have the right to ask about End of Life Care options.
15. You have the right to be treated fairly and independently of your race, religion, ethnicity, color, national origin, gender, age, political beliefs, physical or mental impairments, marital status, sexual preference, sexual identity or source of payment.
16. You will not be deprived of any benefits, rights, or privileges guaranteed by federal or state law but subject to your responsibilities.
17. You have a right to influence the operation of Family Health Care through our Board of Directors, who represents the communities we serve.
18. You have the right to call your Family Health Care office after hours for urgent issues and will be helped by our on-call staff. (365 days/year).
19. You have the right to be informed and to consent in writing to minor surgical/dental procedures using local anesthesia performed at Family Health Care.
20. You have the right to request us not to bill your health plan if you pay upfront for services.
21. As a patient of Family Health Care, you have the right to have your prescriptions sent to the pharmacy of your choice.

Your Responsibilities

1. Be respectful of our health care providers, staff, other patients and facilities.
2. To schedule an appointment to see a provider except in unusual circumstances.
3. If, for any reason, you cannot keep your appointment, you should notify Family Health Care at least 24 hours before your appointment to reschedule so others may be seen.
4. You need to take an active role in your healthcare and inform your provider of all significant medical illnesses, surgeries, hospitalizations, Emergency Room visits, medications and allergies.
5. In order for the provider to arrive at a correct diagnosis and treatment plan, you must be open and honest about your symptoms, lifestyle, and concerns.
6. To respect others, you must avoid knowingly spreading infection and follow the recommended infection control practices of the clinic.
7. If your condition changes, or if you have a problem with your treatment, you should notify your PCH team immediately.
8. If you do not understand your diagnosis or treatment plan, you need to notify your PCH team.
9. Recognize the reality of risks and limits of the science of health care and human fallibility.
10. Inform your PCH team if you have a Living Will, Power of Attorney, or other Advanced Directives that could affect your end of life care.
11. If you do not actively participate in your health care, you may be asked to find another provider.
12. In most cases, we are able to bill your insurance for you; however you are responsible for payment of co-insurance deductibles and non-covered services at the time of your visit.
13. To address concerns that may arise, please utilize our internal grievance process by notifying the Site Facility Manager.
14. Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.

Family Health Care is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).

I have read and understand my responsibilities as a patient of this practice. I understand that it is imperative that I meet these responsibilities so that my Provider can provide the optimum care for me.

Patient's Name _____ Date of Birth _____

Patient/Parent/Legal Guardian Signature _____ Date _____

As your Provider, I understand my responsibilities to you as a patient of this practice. I will do my best to provide you with the highest quality of care possible.

Provider's Name _____