JUPITER FAMILY MEDICINE
ADULT HEALTH HISTORY

Live well. Feel well.

NAME _____ Date of Birth _____

MEDICAL HISTORY

Please indicate if you have had the following (date/describe):

High cholesterol	Y	N		Ulcer	Y	N	
High blood pressure	Y	N		Reflux (GERD or persistent heartburn)	Y	N	
Diabetes	Y	N		Irritable bowel syndrome	Y	N	
Heart attack	Y	N		Arthritis	Y	N	
Coronary artery by pass graft	Y	N		Migraine	Y	N	
Heart failure	Y	N		Seizure disorder	Y	N	
Other heart disease	Y	N		Kidney disorder	Y	N	
Stroke	Y	N		Anemia	Y	N	
Coronary artery - angioplasty/ stent/surgery	Y	N		Liver disease	Y	N	
Cancer	Y	N		Sexually transmitted disease	Y	N	
Abnormal pap smear	Y	N		Blood transfusion	Y	N	
Fibrocystic breast disease	Y	N		Alcoholism	Y	N	
COPD/Emphysema	Y	N		Substance abuse	Y	N	
Asthma	Y	N		Depression	Y	N	
Allergies	Y	N		Anxiety disorder	Y	N	
Hypothyroidism	Y	N		Bipolar disorder	Y	N	
Other thyroid problems	Y	N		Other psychiatric disorder	Y	N	

Do you have any other problems for which you have been taking medications or seeing a doctor on a regular basis? Please list.

_____

_____

_____

Surgeries (please list type of surgery and date - include outpatient procedures such as breast biopsy, colposcopy, etc...):

_____

_____

_____

MEDICATIONS

Please list those taken regularly (please include over the counter medications, vitamins, and herbal supplements):

Medication	Dose	Times/Day

What pharmacy would you like prescriptions filled at?

_____

ALLERGIES

Are you allergic to any medications?

Medication What happens when you take it?

_____

_____

_____

SOCIAL HISTORY

Married Divorced Single Widowed

Occupation _____

Do you smoke? Y N

if yes, amount per day _____ for how long _____

if you've ever smoked, when did you quit? _____

Do you drink alcohol? Y N

if yes, amount per week _____

Do you currently, or have you ever, used street drugs? Y N

if yes, type of drug _____

SIDE 2

FAMILY HISTORY

Have any members of your immediate family (mother, father, brothers, sisters or grandparents) had any of the following?
If yes, please indicate which family member.

Cancer:				Allergy	Y	N	
Breast	Y	N		Asthma	Y	N	
Colon	Y	N		Osteoporosis	Y	N	
Other _____	Y	N		Rheumatoid arthritis	Y	N	
Heart attack	Y	N		Other arthritis	Y	N	
Coronary artery bypass graft	Y	N		Kidney disease	Y	N	
Premature CAD	Y	N		Liver disease	Y	N	
Heart failure	Y	N		Alzheimer's disease	Y	N	
High blood pressure	Y	N		Depression	Y	N	
High cholesterol	Y	N		Anxiety disorder	Y	N	
Diabetes	Y	N		Suicide	Y	N	
Obesity	Y	N		Alcohol/drug abuse	Y	N	
Stroke	Y	N		Tuberculosis	Y	N	
Hypothyroidism	Y	N		Sickle cell disease	Y	N	
Other thyroid problems	Y	N		Other genetic disease/ birth defect	Y	N	
Migraine	Y	N					
Seizure	Y	N					

List any additional medical problems and cause of death (if applicable):

Father _____

Mother _____

Brothers _____

Sisters _____

Grandparents _____

Children _____

I certify that the answers on my health history are true and accurate.

Signature _____ Date _____

Jupiter Family Medicine, P.C.

Patient Information – Please Print

Name_____ Date of Birth _____ Age _____
Last First M.I.

Address_____ City_____ State_____ Zip_____

Primary Phone ( )_____ Secondary Phone ( ) _____ Alt. Phone ( ) _____

Marital Status_____ Male/Female ___ Social Security Number_____ Driver's License # _____

Employer _____ Occupation _____ Spouse's Name _____

Race_____ Preferred Language_____ Ethnicity- Not Hispanic or Latino,
Hispanic or Refuse to Report-Circle one

Email Address:_____

Name of nearest relative with whom you do NOT live with and whom we may contact in case of emergency.

Name _____ Address _____ Phone ( ) _____

Insurance Card Holder's Information **Relationship to Patient**_____

Name_____ Date of Birth _____ Age _____
Last First M.I.

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Work/Other Phone ( ) _____ Cell Phone ( ) _____

Marital Status_____ Male/Female ___ Social Security Number_____ Driver's License # _____

Employer _____ Occupation _____ Spouse's Name _____
Last First M.I.

Primary Insurance Carrier _____ Insurance Card Holder _____

Policy No_____ Group No _____ Phone No (____) _____

Secondary Insurance Carrier _____ Insurance Card Holder _____

Policy No_____ Group No _____ Phone No (____) _____

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a coetaneous, mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (HBV) blood test will be performed.

Signature_____Print Name _____Date_____

I authorize payment of medical benefits by the insured directly to Jupiter Family Medicine PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself and my family members for any yearly deductible or co-payment amounts. I agree to pay all services within 30days unless a payment plan is negotiated in advance. I authorize Jupiter Family Medicine PC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature_____Print Name_____Date_____

Jupiter Family Medicine, P.C.

Patient Consent for Use and Disclosure Of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby give my consent for Jupiter Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Jupiter Family Medicine describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jupiter Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.

_____ Please initial to acknowledge that you have reviewed Jupiter Family Medicine's Notice of Privacy Practices.

I request that all communications to me (by telephone, mail, etc.) by Jupiter Family Medicine and/or its staff be handled in the following manner:

- For **written** communications: Address to: _____

  _____

  _____

- For **oral** communications: Call: _____
  (telephone number)

  May we leave a detailed message? ☐ YES ☐ NO

In the event that I am unavailable, I give Jupiter Family Medicine authority to share PHI with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

With this consent, Jupiter Family Medicine may call the number above and leave a message on voice mail or with a listed individual in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Jupiter Family Medicine may mail to the address above any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and items pertaining to my clinical care, including laboratory test results, among others. I have the right to request that Jupiter Family Medicine restrict how it uses or discloses by PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

If the above address is <u>not</u> your home address or primary mailing address, please provide us with an alternate address for purposes of ensuring payment:

_____

_____

In the event that a document containing PHI, such as medical records, a completed form, or a prescription, will be picked up at the office of Jupiter Family Medicine, I give Jupiter Family Medicine the authority to release the items to the following individuals (a photo ID will be required):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this form, I am consenting to allow Jupiter Family Medicine to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jupiter Family Medicine may decline to provide treatment to me.

_____ _____

Patient/Patient Representative Signature Date

_____

Relationship to Patient (if other than patient)

For Practice Use Only:

Practice: □ Accepts □ Denies

_____ _____

Privacy Officer Signature Date

Live well. Feel well.

Jupiter Family Medicine, PC

Rose Ramirez, M.D. Mike Ahern, PA-C
Cathy Hallenbeck, PA-C Cheri VanWynGarden, NP
6250 Jupiter Ave NE, Ste A Belmont, MI 49306

PAYMENT POLICY

Thank you for choosing us as your primary care providers. We are committed to providing you with quality and affordable health care.

Missed or No-show Appointments: Patients who do not show up for a scheduled appointment with a provider, or who call to reschedule/cancel an appointment less than one business day prior to the appointment, may be charged a fee. This fee is **$30.00** for a regular appointment, **$50.00** for a well-child exam, and **$70.00** for an adult physical. If we are able to fill the appointment spot, you may not be charged.

Insurance: We participate with many insurance plans, including Medicare. However, we do not participate with Medicaid. If you are not insured by a plan or we do not participate with your plan, payment is expected in full at each visit. *We are not allowed to accept cash payments from patients with Medicaid insurance.* If we are not provided with correct insurance information and are required to bill your insurance again, there may be a **$5.00** charge added to your account.

Proof of Insurance: We do our best to validate insurance coverage prior to your appointment However, all patients may be asked to provide a current valid insurance card and driver's license as proof of insurance. If you do not provide an up-to-date insurance card at the time of your visit and the information we have is incorrect, you may be responsible for your full account balance. When a patient provides corrected insurance information in a timely manner, we will do our best to have your insurance cover the cost of the visit, however you may still be responsible for the full account balance if your insurance fails to pay for the visit due to "timely filing" requirements.

Deductible & Co-Pays: Co-pays must be paid at the time of service or a **$5.00** billing charge may be added to your bill. Patients with a high deductible plan (typically those without a co-pay), will be asked to pay **$50.00** when checking out, to cover a portion of their anticipated deductible. Patients who do not know their co-pay amount will be asked to pay **$30.00** when checking out, to cover their anticipated co-pay amount.

Non-Covered Services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance provider. Please contact your insurance company with any questions regarding your coverage.

Non-Payment: Action may be taken if no payment is received on the account within 90 days of the service(s) rendered.

Returned Checks: For payments made by check which is returned unpaid from the bank, a **$25.00** fee may be charged.

New Phone Prescriptions: If a new prescription is given at the patient's request without an office visit, a **$20.00** charge may be added to your account.

Form Charges: There may be a charge ranging from **$10-$35**, for a form or work notice to be completed without an office visit. Examples of such forms include: sports physical forms, FMLA paperwork, Insurance forms, work notes, etc, based on the length and/or complexity of the form.

Patient Records: We must have a signed authorization before records can be released. In addition please be aware there may be a charge for the records, as follows:

$15.00 for a CD upon which the records will be saved in .pdf format.
$15.00-$20.00 for a paper copy of the chart (depending on the size of the chart).

Patient Name: _____ Date of Birth _____

Patient/Guardian Signature: _____ Date _____

Jupiter Family Medicine, PC

6250 Jupiter Ave Suite A, Belmont, MI 49306 P: (616) 301-2500 F: (616) 301-2501

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth _____

I, the undersigned authorize you to furnish a copy of the following medical records to _____

- ☐ Laboratory Data (last 3 years)
- ☐ Radiology Reports (last 3 years)
- ☐ Progress/Doctor's Notes
- ☐ Operative Reports, Findings and Complications
- ☐ Other Documents (please specify) _____
- ☐ Hospital Notes
- ☐ ER Notes
- ☐ Pathology Reports

Physician/Practice releasing records:
Name: _____
Address: _____
City: _____ Zip: _____
Phone: _____
Fax: _____

Physician/Practice to receive records:
Name: Jupiter Family Medicine, PC
Address: 6250 Jupiter Avenue, Suite A
City: Belmont, MI 49306
Phone (616) 301-2500
Fax: (616) 301-2501

I authorize the release of these medical records *to* **Jupiter Family Medicine, PC** from all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment

I authorize Jupiter Family Medicine, PC to release my medical records regarding their treatment relevant healthcare providers, facilities and diagnostic centers involved in the course of my treatment.

I specifically consent to the disclosure of records to Jupiter Family Medicine, PC that may contain alcohol/drug/substance abuse information. I specifically consent to the disclosure of these records by Jupiter Family Medicine, PC to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

I specifically consent to the disclosure of records to Jupiter Family Medicine, PC that may contain HIV test results or diagnosis of AIDs and AIDs related conditions. I specifically consent to the disclosure of these records by Jupiter Family Medicine, PC of relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment _____ (initials)

I specifically consent to the disclosure of records that contain mental health information, I specifically consent to the disclosure of these records by Jupiter Family Medicine, PC to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature or as otherwise specified by date, event or conditions(s) as Follows: _____
_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: Jupiter Family Medicine, PC Attn: Privacy Contact 6290 Jupiter Ave Suite A Belmont, MI 49306. I understand that a revocation is not effective to the extent that my physician has relied on the use or 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.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [If applicable because the authorization is obtained for marketing purposes.]

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Effective September 23, 2013

Jupiter Family Medicine, PC

Notice of Privacy Practices

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.

If you have questions about this notice, please contact our Privacy Contact, who is Marianne Olsen.

Your medical information is personal. We are committed to protecting your medical information. We created a record of the care and services you received at the Practice. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the Practice whether made by your personal physician or one of the office's employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

Jupiter Family Medicine is required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
3. Follow the terms of the Notice that is currently in effect.

How this Office May Use and Disclose Your Medical Information:

The following describes the different ways that your medical information may be used or disclosed by the Practice. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

For Treatment: We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, physician assistants, nurse practitioners, nurse midwives, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. 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 the treatment.

To Individuals Involved in Your Care or the Payment of Your Care: We may disclose medical information about you to a family member or close friend involved in your medical care. We may also

give information to someone who is involved with payments or helps pay for your care. Additionally, we may disclose information for notification purposes such as your location or general condition.

For Health Care Operations: We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, 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 combine medical information about many of our patients to decide what additional services the Practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, physician assistants, nurse practitioners, nurse midwives, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Practice.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Worker's Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety: 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 another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities: We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement: We may release medical information about you if required by law when asked to do so by a law enforcement officer.

Coroners and Medical Examiners: We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Other Uses of Medical Information:

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose your medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Your Rights Regarding Your Medical Information:

You have the following rights regarding the medical information Jupiter Family Medicine maintains about you:

Right to Inspect and Copy: You have the right to inspect and obtain an electronic or hard copy of your medical information with the exception of any psychotherapy notes.

To inspect and obtain a copy of your medical information, you must submit your request in writing to Marianne Olsen. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain copies of your medical information in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review, contact Marianne Olsen.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by the Practice.

To request an amendment, your request must be made in writing and submitted to Marianne Olsen. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) Was not created by us;
b) Is not part of the medical information kept by this office;
c) Is not part of the information which you would be permitted to inspect and copy; or
d) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of non-routine disclosures." This is a list of the disclosures this office has made of your medical information.

To request this accounting of disclosures, you must submit your request in writing to Marianne Olsen. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure we make of your medical information.

We are not required to agree to unreasonable requests for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

The practice will honor any request for restrictions of disclosures to a health plan for payment or health care operation purposes, if the PHI relates solely to a health care item or service for which you have paid in full without contribution by the health plan.

To request restrictions, you must make your request in writing to Marianne Olsen.

Right to Request Confidential Communications: You have the right to request that we communication with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Marianne Olsen. We will accommodate all reasonable requests.

Right to a Copy of This Notice: You have the right to a paper or electronic copy of this Notice. If you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact Marianne Olsen.

Revisions to This Notice:

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice at the Practice. *Any revised Notice will contain the effective date on the first page of the notice in the upper right-hand corner.* In addition, each time you visit the Practice we will offer you a copy of the current Notice in effect.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Marianne Olsen, Office Manager at (616) 301-2500. All complaints must be submitted in writing. Our Privacy Officer will review all patient complaints and, if appropriate, conduct an investigation to develop the necessary information regarding the complaint. The results of the Privacy Officer's determination will be communicated to the patient in writing within fifteen (15) business days of receiving the written complaint. If any measures will be taken by the Practice to mitigate any improper uses or disclosures of protected health information, this will also be communicated in the above written communication to the patient.
THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Live well. Feel well.

Jupiter Family Medicine, PC

Rose Ramirez, M.D. Mike Ahern, PA-C
Cathy Hallenbeck, PA-C

The Patient-Doctor Partnership

The health and wellness of our patients is a top concern of Jupiter Family Medicine. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if we, your providers, and you, our patient, work together. This concept is called the **Patient Centered Medical Home**.

Patient Responsibilities:

- 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 provider about any changes in your health and wellbeing.
- Take all of your medicines and follow your provider's advice.
- Make healthy decisions about your daily habits and lifestyles.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Call our office **first** with all problems, unless it is a medical emergency.
- End every visit with a clear understanding of your provider's expectations, treatment goals, and future plans.

Provider Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way.
- Listen to my patients' feelings and questions to help them make decisions about their care.
- Keep treatments, discussions and records private.
- Provide 24 hour access to medical care and same day appointments, whenever possible.
- Provide instruction on how to meet your health care needs when the office is not open.
- To care for you to the best of my abilities based on my understanding of current medical methods available.
- Give my patients clear directions about medicines and other treatments.
- Send my patients to trusted experts, if needed.
- We will help you get the services you need, including referrals for Community Resources, if needed.
- End every visit with clear instructions about expectations, treatment goals, and future plans.

6250 Jupiter Avenue, Suite A Belmont, MI 49306
Phone:(616)301-2500 Fax: (616)301-2501