Leelanau Family Practice

Care for Life

New Patient Information

Patient Name (First)_____(MI) ___ (Last)_____

(preferred name)_____ Preferred pronouns _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ Email _____

How is it best to communicate with you? *Check all that apply.*
__ email __ text messages __ home phone __ cell phone __ can we leave a voice message?

I would like to receive personalized messages from Leelanau Family Practice for? *Check all that apply.*
__ Lab results __ Health Maintenance __ Prescription Sent __ General Notifications (ex. Flu clinic)

Social Security Number # ____-___-_____ Date of Birth ____/____/_____

Birth Sex ___ Male ___ Female
Sexual Orientation __ Heterosexual __ Gay __ Lesbian __ Queer __ Bisexual
__ Other(please state your sexuality)_____
Marital status ___ Single ___ Married ___ Divorced ___ Partner ___ Widowed

Drivers license number _____

Employer _____ Occupation_____

Employers address_____ City _____ State____

Zip code _____ Employer's phone _____

Name _____ Date of Birth _____

Medical Insurance Information

Plan Name _____ ID number _____Group #_____

Name of insured _____ Date of Birth of insured _____

Relationship to Insured _____ Policy Number _____ Start Date _____

Medical History

Are you under the care of a physician now? *(name,phone)*_____

Past Medical History

Have you had or do you have any of the following?

__ High blood pressure (hypertension)
__ High cholesterol
__ Diabetes *(type)* ___
__ Asthma
__ COPD - emphysema
__ Anemia
__ Seasonal allergies (hayfever)
__ Headaches
__ Migraines
__ Heartburn (reflux/GERD)
__ Thyroid disease (hypothyroidism/Graves disease)
__ Cancer (type)_____
__ Leukemia (type)_____
__ Kidney disease
__ Liver disease
__ Alcoholic
__ OTHER _____

_____

__ Dementia (memory loss)
__ HIV/AIDS
__ Seizures/ epilepsy
__ Chron's or Ulcerative Colitis
__ Irritable bowel/ chronic diarrhea or constipation
__ AutoImmune disease
__ Arthritis
__ Stoke(s)
__ Heart attack(s)
__ Congestive heart failure
__ Hepatitis *(type)* ____
__ Chronic Pain disorder (fibromyalgia/PMR/etc)
__ Atrial Fibrillation (a fib)
__ Osteoporosis or osteopenia
__ Substance Abuse
__ Congenital disorder _____

Surgical History

Please list all surgeries, procedures or interventions and dates.

DATE PROCEDURE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Leelanau Family Practice PC, Jessica Paquette DO, Jennifer Littlefield FNP, Molly Lowe FNP
718 N St Joseph St, K1, Suttons Bay, Mi 49682 Phone (231)386-0088 Fax (855)537-4321

Name _____ Date of Birth _____

Allergies

Please list all allergies and the reaction you had to it.

ALLERGEN	REACTION

Medications

Please list all medications you take including supplements

Medication	Dose	Frequency

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Substance Use History

Do you use tobacco products? __ Yes __No __ Quit*(date)*_____

If yes, do you smoke? __ Yes __ No

Vape? __ Yes __ No

Chew? __ Yes __ No

Do you drink alcohol? __ Never __ once a month or less __ monthly __ weekly __ daily

When drinking,How much do you drink daily? __1-2 drinks __3-4 drinks __5-6 drinks __often more than 6/day

How often do you have more than 6 drinks in a day? __ never __ occasionally __ often

Have you ever considered cutting down on your drinking? ___ Yes ___ No

Do you use (have used) other substances? ___ No ___ Marijuana ___ Cocaine ___ Meth __ PCP

___ Mushrooms ___ Heroin ___ Opioids(not prescribed to you)___ other

Cancer Screening

Over 45 years old, date of your last colon cancer screen? _____ colonoscopy _____ cologuard ____ other

Female Patients

Date of last Pap smear (over 21 years old)? _____

Date of last Mammogram (over 40 years old)? _____

Male Patients

Date of PSA (over age 40)? _____

Vaccination History (Y=vaccinated, N=not vaccinated, D=had disease)

Y/N/D	Date	Vaccine	Other details
____	_____	DtaP (Diphtheria, tetanus,pertussis)	_____
____	_____	MMR (Measles,Mumps,Rubella)	_____
____	_____	Hepatitis B	_____
____	_____	Yearly influenza (Flu)	_____
____	_____	COVID 19	_____
____	_____	Shingles	_____
____	_____	Pneumonia	_____
____	_____	HPV (human papillomavirus)	_____
____	_____	Meningitis (Meningococcal)	_____
____	_____	Chicken Pox (Varicella)	_____
____	_____	Hepatitis A	_____
____	_____	Other	_____
____	_____	Other	_____

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Name _____ Date of Birth _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my Protected Health Information (PHI) as defined under the Federal HIPAA Privacy Rule (45 CFR, Parts 160 and 164), by Leelanau Family Practice PC; for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Leelanau Family Practice PC. I understand that diagnosis or treatment of me by the providers of Leelanau Family Practice PC may be conditioned upon my consent as evidenced by my signature on this document. I understand that the information in my health record may include information relating to sexually transmitted diseases, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV). These records may include information about behavioral or mental health services I have received, including any treatment for alcohol and drug abuse, which may include records protected under the regulations in 42 CFR, Part 2. I understand that the information in my health record may include information relating to psychological services records, including communications made by me to a social worker or psychologist, and that I specifically authorize the use and disclosure of psychotherapy notes pursuant to 45 CFR §164.508. I also specifically authorize the use and disclosure of records containing information relating to sexually transmitted diseases, behavioral or mental health services and drug and alcohol treatment and abuse. I understand that Leelanau Family Practice PC has entered into an agreement with Munson Medical Center and Northern Physician Organization under which some elements of my PHI will be placed on a Community Electronic Medical Record. I further understand that healthcare providers in addition to the providers at Leelanau Family Practice PC will have access to my PHI on the Community Electronic Medical Record. I consent to my PHI being placed on the Community Electronic Medical Record for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, quality assessment monitoring or to conduct health care operations. I have the right to revoke this consent in writing at any time, except to the extent that the providers of Leelanau Family Practice PC have taken action in reliance on this consent under Federal. I understand that if I revoke this consent my PHI will remain on the Community Electronic Medical Record. My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Leelanau Family Practice PC Notice of Privacy Practices prior to signing this document. The Leelanau Family Practice PCs Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Leelanau Family Practice PC. The Notice of Privacy Practices for Leelanau Family Practice PC is also provided in the main lobby of the office at 718 St Joseph St, Suttons Bay, MI and on the Leelanau Family Practice PC website at www.leelanaufp.com. This Notice of Privacy Practices also describes my rights and the Leelanau Family Practice PC's duties with respect to my PHI. Leelanau Family Practice PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Leelanau Family Practice PC's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature_____date_____

Name _____ Date of Birth _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____D.O.B._____
Street Address:_____
City: _____ State: _____ Zip Code: _____

Requesting records from:

Previous Physician or Facility Name: _____
Phone: _____ Fax: _____
Street Address:_____
City: _____ State: _____ Zip Code: _____

Purpose of Disclosure: **Transfer of Care**

Please fax records to* 855-537-4321 *"*Leelanau Family Practice PC*" or provide digital copy on USB drive, rather than sending a paper copy.

Information to be Released:

All office visit notes, lab tests, x-rays, consultation reports, problem lists -
*unless specified dates follow. ***From ____/____/_____ to ____/____/_____**

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:

_____Do **not** release Alcohol and/or Drug Abuse information.
_____Do **not** release Behavioral Health Information

Acknowledgement of Understanding:

- I understand the expiration date of this authorization is 180 days from the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I understand that, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with Michigan law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that a photocopy or fax of this form is the same as the original.
- I understand, if applicable, that (1) my HIV test results may be released without my authorization to persons/organizations that have access under Michigan law, and that (2) a list of those persons/organizations is available upon request.
- I authorize and request any and all of my medical information, as indicated above be released according to the terms outlined in this agreement.

Patient Signature:_____Date:_____

Signature of Authorized Person _____ Date:_____
Relationship to Patient _____ Witness Signature_____

This information may include any of the following, unless otherwise identified: Alcohol or drug abuse, mental health treatment information protected under Title 42 of Code of Federal Regulations, Part II Serious communicable and infectious disease as defined by the Michigan Department of Community Health Code 1989, Act 174. Which includes Venereal Disease, Tuberculosis, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Comples (ARC) and Hepatitis. Revocation of this consent is available at any time, except to the extent that release of information has already occurred in reliance upon this consent. The duration of this consent without

Name _____ Date of Birth _____

Medical Information (HIPAA) Release Form

PATIENT NAME:_____**DATE OF BIRTH**: _____

By listing the persons below, I am authorizing any employee Leelanau Family Practice to release information contained in my patient records, which may include alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any social services records, if any mental health records, including communications made by me to a social worker or mental health professional, if any and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV) test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the individuals listed below, only under the conditions listed below:

☐ □ Do not release any information to anyone.

☐ □ I authorize information to be released to:

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

☐ □ Emergency Contact : (this person will not be authorized access to any medical information unless indicated above.)

Name _____ **Relationship** _____ **Phone** _____

Messages from doctor's office:

May include: Appointment confirmation and new prescriptions or refills that have been sent to your pharmacy.

I would like to receive appointment and prescription messages via:

- ☐ Text messages
- ☐ Phone Call
- ☐ Emails
- ☐ Portal

_____ Patient Signature

_____ Date

Office Use: EMessenger_____ Contacts Entered_____

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MEDICAL APPOINTMENT CANCELLATION - NO SHOW POLICY

Effective June 1st, 2018, any patient who fails to show, cancel or reschedule an appointment and has not contacted our office within ***one business day prior*** will be considered a **No Show**.

Established Patients:

If an established patient has a **No Show** for an appointment; a letter will be sent to reschedule your appointment and will be considered for a $50.00 fee

Any established patient who is a **No Show** for an appointment a second time; a letter will be sent as a warning and to reschedule. The patient **will** be charged a $50.00 fee.

If a third **No Show** should occur; the patient **will** be charged a $50.00 fee and may be dismissed from Leelanau Family Practice.

New patients who fail to show for their initial visit will ***NOT*** be rescheduled.

The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will still remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office.

You may contact Leelanau Family Practice 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Messages left are acceptable as long as they are received one business day prior to the date of the appointment being canceled.

Leelanau Family Practice (231)386-0088

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature_____date_____