

Dear Patient,

We would like to welcome you to our office. We appreciate your confidence and take great pride in providing high quality medical care for our patients. Enclosed you will find some patient information that will help familiarize you with our facility. Also enclosed is a medical history and registration information form to be completed at your convenience prior to your visit. Please bring these, as well as your insurance identification card and drivers license (picture identification). If you have any questions after reading the material, our office staff will be happy to answer them for you by telephone prior to your visit.

Our office is located either:

Providence Park - Outpatient Services Building
47601 Grand River Ave, Suite 218
Novi, MI 48374
(248) 465-4010 phone
(248) 465-4011 fax

Coming from the east/west on I-96:
Take I-96 to the Beck Road exit (exit160). Turn South onto Beck Road toward Grand River. The entrance to use is the only one that faces Grand River Ave with statues in front of it.

OR

Providence Hospital Pavilion
22255 Greenfield Road, Suite 130
Southfield, MI 48075
(248) 849-4880 phone
(248) 849-4881 fax

Coming from the east/west via 696:
Take I-696 to the Greenfield Road exit. When coming South on Greenfield Road, we are just past 9 Mile Road, on the right side of the street. Coming North on Greenfield, our office is between 8 and 9 Mile Roads.

AN IMPORTANT MESSAGE

Our office recently instituted a policy applying a charge for appointments not cancelled and not kept. We attempt to ensure all patients receive timely care. When an appointment is neither kept nor cancelled, it causes an unnecessary delay in care for patients who must wait for later dates. In addition, we recently added an automated telephone appointment reminder system to ensure scheduled patients have adequate time to contact our office in cases where it is necessary to cancel.

Due to this policy, we will be adding a \$25.00 charge to your billing account for failure to inform us of your inability to keep your appointment. You are considered personally responsible for this charge, as it is not payable by your health insurance plan.

If you have any question regarding this policy, please feel free to contact our office.

We appreciate you selecting our office for your medical care and we look forward to meeting you.

Patient Information Sheet
(Please Print)

Date _____ Doctor's Name _____

Name _____
Last First

Address _____
Street City State Zip

Telephone _____
Home Work Cell

Date of Birth _____ Age _____

Social Security Number _____

M F Marital Status: M D W S Separated

Name of Spouse: _____

Pharmacy Name, Telephone & Address:

Patient Occupation _____

Employer _____ Business Phone _____

Employer Address _____

Spouse's Occupation _____

Employer _____

Employer Address _____

Phone Number _____

Social Security Number _____ Date of Birth _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Phone Number _____

Relationship _____

I hereby authorize Providence Hospital to furnish the requested diagnostic services and/or treatment.

(Signature)

Patient Name _____

Date _____

Thank you for making an appointment for your first visit to our office. These questions are intended to assist you in providing me with information related to your health. If there are questions which are unclear to you, please leave them blank and we will discuss them at your visit.

1. Do you have any current concerns or problems with your health? Y N

If so, please

describe: _____

2. Please list all medications (prescription and over the counter) that you take on a regular basis and bring all of these to your appointment. Circle any you may need refilled at your visit.

3. Do you use a mail service pharmacy to obtain your medications? Y N

4. Are you allergic to any drugs? Y N Please indicate which:

5. Do you use any other drugs (marijuana, cocaine, etc?) Y N

6. Is there anything else you would like to discuss?

PLEASE BE SURE TO BRING YOUR INSURANCE CARD AND REFERRAL FORM (IF REQUIRED BY YOUR INSURANCE) FROM THE OFFICE REFERRING YOU. ALSO BRING ANY TEST RESULTS, XRAYs, OR REPORTS FROM YOUR DOCTOR WITH YOU TO YOUR APPOINTMENT.



GENERAL CONSENT TO OUTPATIENT TREATMENT CONSENT TO PHYSICIAN OFFICE, CLINIC, OR OUTPATIENT SERVICES

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostics procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES

I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The St. John Health Notice of Privacy Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the St. John Health website at www.stjohn.org or by contacting the Privacy Officer listed in the notice

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the St. John Health Notice of Privacy Practices.

Name of Patient (print) _____

Signature of Patient _____

Date _____

Time _____

Signature of Spouse _____

Date _____ **Time** _____

Signature of Witness _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative _____

Date _____ **Time** _____

Relationship _____

Address _____

Phone Number _____

Signature of Witness _____



ADULT DATA BASE

Name _____ Referred By _____ Date _____

Birthdate _____ Birthplace _____ Occupation _____

PMH - DM, Thyroid, HTN, MI, Rheumatic Fever, Cardiac, CVA, Pulm, Renal, Hepatitis, Liver, PUD, CA, Epilepsy, Mental Illness

SURGERY / HOSP - _____

TRAUMA - Head Injuries, Fractures, Accidents _____

MEDICATIONS -

ALLERGIES (TYPE RXN) - _____

IMMUNIZATIONS - dT Rubella Polio PPD Flu Pneumovax Heptavax Other

Dates:

SOC. HX: Marital Status _____ Children _____ Religion _____

Living Situation _____

Education / Work HX (Exposures) _____

HABITS: ETOH _____ Tobacco _____ Caffeine _____

Exercise _____ Diet _____

Seat Belts _____ Stress Management / Hobbies _____

FAM HX:

SIGNATURE

REVIEW OF SYSTEMS

DATE:

NORMAL	DESCRIBE ABNORMALITIES UNDER THE APPROPRIATE HEADING	
GENERAL: fever, night sweats, chills, weakness, sleep appetite, weight change		
SKIN: color, hair, itch, nails, chronic rash, eczema, changing moles		
EYES: vision, inflammation, glaucoma, cataracts, diplopia		
EARS, NOSE, THROAT: hearing, infection, smell, epistaxis, voice change, sores, vertigo, tinnitus		
RESPIRATORY: SOB, chronic cough, asthma, wheeze, cyanosis, frequent infection, hemoptysis		
BREASTS: discharge, masses, tenderness, self-exam		
CARDIOVASCULAR: palpitations, syncope, pain, edema, hx murmur, HTN, orthopnea, PND, thrombophlebitis, claudication		
GI: dysphagia, nausea, vomiting, gas, diarrhea, constipation, bleeding, pain, jaundice, ulcers, hemorrhoids		
URINARY: scrotal masses, pain, volume, retention, incontinence, bleeding, stones, frequency, infection, VD		
MENSTRUATION: Q _____ d, x _____ d LMP _____, Last Pap _____ dysmenorrhea, spotting, irregular G ____ P ____ Spon. Ab ____ Elec. Ab _____ heaviest baby _____ contraception _____ menarche _____ menopause _____ DES exposure, estrogen Rx infection - vaginitis, PID, VD		
SEXUAL: libido, impotence, dyspareunia		
PSYCH: anxiety, depression, mood swings, attention span, past Rx, insomnia		
NEURO: headaches, tremors, "spells", balance, sensation, seizures, "stroke", speech		
ENDO: goiter, heat/cold intolerance, irradiation exposure, polydipsia/polyuria, change in physical features		
MUSCULOSKELETAL: pain, cramps, swelling, stiffness, weakness, osteoporosis, calcium intake		
HEME: bleeding, bruising, anemia, transfusions		
ALLERGIC: hayfever, insect stings, foods		

SIGNATURE



St. John Health Notice of Privacy Practices

1. 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.

2. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information “protected health information” or “PHI” for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Health facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at www.stjohn.org.

3. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

We may use and disclose your PHI for the following reasons:

- 3.1.1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you’re being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.
- 3.1.2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.
- 3.1.3. **For health care operations.** We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and others in order to make sure we are complying with the laws that affect us.

3.2. Certain Other Uses and Disclosures That Do Not Require Your Consent

- 3.2.1. **When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.
- 3.2.2. **For public health activities.** For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual’s death.
- 3.2.3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- 3.2.4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
- 3.2.5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct research.
- 3.2.6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- 3.2.7. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- 3.2.8. **For workers’ compensation purposes.** We may provide PHI in order to comply with workers’ compensation laws.
- 3.2.9. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.
- 3.2.10. **Fundraising activities.** We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

3.3. Uses and Disclosures to Which You Have an Opportunity to Object

- 3.3.1. **Patient directories.** We may include your name, location in this facility, general condition and religious affiliation (if any) in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part.
- 3.3.2. **Disclosure to family, friends, or others.** We may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.
 - 3.3.2.1. Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

3.4. All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- 4.1. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
- 4.2. The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.
- 4.3. The Right to See and Get Copies of Your PHI.** In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
If you request copies of your PHI, we will charge you a reasonable copying fee.
- 4.4. The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures listed in section 3.1, 3.2 and 3.3. The list also will not include any uses or disclosures made before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you \$25 for each additional request.
- 4.5. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.
- 4.6. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **St. John Health HIPAA Privacy Office** - (See section 7 of this Notice.)

You also may send a written complaint to:

Secretary of the Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

We will take no retaliatory action against you if you file a complaint about our privacy practices.

6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments and units of the following entities:

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for purposes of treatment, payment, or hospital operations as described in this notice.

Brighton Hospital	St. John Home Infusion	Michigan Ear Institute
Providence Hospital and Medical Centers	St. John Home Medical Equipment	Michigan Institute for Sleep Medicine & Cardiopulmonary Services
St. John Detroit Riverview Hospital	Medical Resources Group	Michigan Pain Management Consultants, P.C.
St. John Hospital and Medical Center	Michigan Mobile Lithotripsy	Newland & Associates, P.C.
St. John Macomb Hospital	Eastwood Clinics	Northland Anesthesia Associates, P.C.
St. John NorthEast Community Hospital	St. John Health Foundation	Novi Pediatric Associates, P.C.
St. John North Shores Hospital	St. John Health Occupational Health Partners	PMHC Cancer Center
St. John Oakland Hospital	Affiliated Health Services, Inc.	Providence Health Foundation, Inc.
St. John River District Hospital	Community Health Investment Corp.	Providence Home Infusion
Father Murray Nursing Center	St. John Health	Southfield Radiology Associates, P.C.
St. John Senior Community	Craniofacial Institute	Vinay Malviya, M.D., P.C.
St. John Home Care	Gynecologic Oncology, P.C.	Open MRI of Michigan, L.L.C.
St. John Hospice	Ian Jackson, M.D., P.C.	
	Independent Emergency Physicians, P.C.	

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for purposes of treatment, payment, or hospital operations as described in this notice.

7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the Providence Hospital HIPAA Privacy Officer at 248-849-2250. All complaints must be submitted in writing to:

Providence Hospital
HIPAA Privacy Officer
16001 West Nine Mile Road
Southfield, MI 48075

8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003.