STEPHEN J. ARNTZ, M.D. • CLARK E. CONANT III, D.O. • LEZLIE MALSON, F.N.P.-C.
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Hello! Welcome to Mid-Michigan Health Centers

Enclosed is your **NEW PATIENT** packet. Please complete and bring with you to your appointment. Please place the completed forms back in the envelope they were mailed in and **do not fold them.** This will assist us better when creating your chart.

You will also need to bring the following items:

- Driver's License
- Insurance Card(s)
- List of Current Medications
- Payment for Co-Pays/Deductibles

Some of the paperwork can be a bit tricky, so here are a few guidelines.....

Demographic Sheet – Please fill this out completely, it is what we look to first to make contact with you.

History Sheet – Please complete these forms to the best of your ability. We understand that you may not know everything we ask, but please do your best.

Medical Records Release – This form is for transferring your records from your **previous** doctor's office to our office. If you do not wish to have medical records transferred or do not have a previous doctor, please do not fill out.

Notice of Privacy Practices – This is our HIPAA (Health Insurance Portability Accountability Act) Policy which protects your privacy and medical information. Please sign the back page of this form. The complete Notice of Privacy Practices is available to you upon request.

Prescription Policy – Please **read, sign and date.**

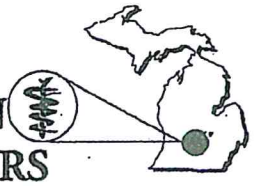
Financial Policy – Please **read, sign and date.**

PCMH Patient/Provider Agreement (PPA) – This is a summary of our agreement with you as a Patient Centered Medical Home for your review.

After Hours Care Policy – For your review

We look forward to meeting you!

214 N. West Ave. • Jackson, MI 49201 • Tel: 517-784-9189 • Fax: 517-784-9657



MID-MICHIGAN
HEALTH CENTERS

Adult Health History Form

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control, herbs, etc.

Medication Dose (e.g., mg/pill) How many times per day

_____

_____

_____

_____

Allergies or reactions to medications: ☐ None _____

OTHER HEALTHCARE PROVIDERS: List any providers you see including eye doctors, dentist, chiropractors, etc.

_____

_____

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy_____ or Colonoscopy _____ Date_____ Abnormal? ☐ Yes ☐ No

Women: Mammogram: Date_____ Abnormal? ☐ Yes ☐ No

Pap Smear: Date_____ Abnormal? ☐ Yes ☐ No

Dexascan (osteoporosis): Date_____ Abnormal? ☐ Yes ☐ No

Men: PSA (prostate): Date_____ Abnormal? ☐ Yes ☐ No

Last Eye Exam: Date_____

Last Dental Exam: Date_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems.

☐ Heart disease:
specify type_____
☐ Asthma/Lung disease
☐ Frequent or difficult urination
☐ High blood pressure
☐ Diabetes
☐ Thyroid problems
☐ Other: (specify)_____
☐ High cholesterol
☐ Kidney disease
☐ Cancer: (specify)_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism_____
Cancer, specify type_____
Heart disease_____
Depression/suicide_____
Genetic disorders_____
Diabetes_____
High cholesterol_____
High blood pressure_____
Stroke_____
Bleeding or clotting disorder_____
Asthma/COPD_____
Other_____

Patient's Name_____ DOB_____ Date_____

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

WOMEN'S HEALTH HISTORY: # pregnancies_____ # deliveries_____ # abortions_____ # miscarriages_____

Age at start of periods_____ Age at end of periods_____

SOCIOECONOMICS: Occupation_____ Employer_____

Spouse/partner's name_____ Number of children/ages_____

SOCIAL HISTORY:

Tobacco Use

Cigarettes: ❑ Never ❑ Quit Date_____ ❑ Current Smoker: packs/day_____ # of years_____

Other Tobacco: ❑ Pipe ❑ Cigar ❑ Chew

Are you interested in quitting? ❑ Yes ❑ No

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes # drinks/week_____

Is your alcohol use a concern for you or others? ❑ Yes ❑ No

Drug Use

Do you use any recreational drugs? ❑ Yes ❑ No

Have you ever used needles to inject drugs? ❑ Yes ❑ No

MENTAL ASSESSMENT:

Over the past two weeks, have you felt down, depressed or hopeless? ❑ Yes ❑ No

Over the past two weeks, have you felt little interest or pleasure in doing things? ❑ Yes ❑ No

DIET and EXERCISE:

Do you exercise regularly? ❑ Yes ❑ No

What kind of exercise?_____ How long (minutes)_____ How often_____

If you do not exercise, why not?_____

How often do you have caffeine? ❑ None ❑ Coffee/tea/soda ____ cups/day

SAFETY:

Do you feel safe in your home? ❑ Yes ❑ No

Is violence at home a concern for you? ❑ Yes ❑ No

Have you ever been abused? ❑ Yes ❑ No

Date Reviewed:	By (initials):

Patient's Name_____DOB_____Date_____

MID-MICHIGAN
HEALTH CENTERS

Pediatric Health History Form

Child's Name: _____ **Birthdate:** _____

Child's Previous doctor: _____

Child's Dentist: _____ Regular Visits? Yes No

Your Regular Pharmacy (Name/Street): _____

Current Problems/Concerns:

_____

_____

Allergies/Reactions to Medicines, Foods, or Environment (Please list nature of reaction:)

_____

Current Medicines:

_____

Pregnancy & Birth:
Were there any problems with the pregnancy?
___No ___Yes (please specify:) _____

Was the baby full term _____ or premature? _____ if so, how early? _____

Delivered by: ____vaginal birth ____caesarian (please explain why:) _____

Birth weight: _____ Birth length: _____

Delivery Hospital: _____ Your Ob: _____

Past Medical History:
Has your child had any of the following conditions? Please circle all that apply:

Asthma / hay fever / eczema	RSV/Bronchiolitis	Pneumonia
Attention/Learning problems	Seizures/convulsions	Developmental delays
Broken bones/major injuries	Anemia/Bleeding problems	Urinary tract infections
Heart problem or murmur	Chicken pox	Other
Frequent ear infections	Frequent strep infections	_____

Past Surgical History:
Has your child had any operations such as ear tubes, hernia repair, or tonsillectomy?
_____No _____Yes (Please explain- type of surgery, location, dates):

_____

Immunizations: ***Please bring your child's shot record.***

Are your child's immunizations up to date? ___Yes ____No

Social History/ Safety Issues:

The child's parents are: ____married ____ single
____divorced ____ other (specify)_____

Does your child attend daycare during the day or after school? ____Yes ___ No

Do any household members smoke? ____Yes ___No

Any concerns about lead exposure? (old home/plumbing/peeling paint) ___Yes ___No
Has your child had a previous lead test? If so, was it normal or low? ____ Yes ____No

Does your child attend preschool/school? ____Yes ___No Grade: _____

Name of School: _____

Any concerns about school performance? ____ Yes ___No

(specify:)_____

Are there any pets in your home? ____Yes ____No (specify:) _____

Family History:
Please circle any family history of the following and indicate who has/had the condition (mother, father, brother, sister, maternal/paternal grandparent, extended family):

Alcoholism/drug abuse	Yes/No_____
Attention Deficit Hyperactivity Disorder	Yes/No_____
Asthma/hay fever/ eczema	Yes/No_____
Bleeding / clotting problems	Yes/No_____
Cancer	Yes/No_____
Diabetes	Yes/No_____
Heart disease/attack before age 50	Yes/No_____
Hearing Loss/Deafness	Yes/No_____
High blood pressure	Yes/No_____
High Cholesterol	Yes/No_____
Hip problems/dislocations	Yes/No_____
Inherited/genetic diseases/birth defects	Yes/No_____
Kidney Disease	Yes/No_____
Learning Disabilities	Yes/No_____
Mental illness/anxiety/depression	Yes/No_____
Seizures	Yes/No_____
Sudden unexplained death before age 50	Yes/No_____
Thyroid disease	Yes/No_____
Other (please explain)	Yes/No_____

Thank you for taking the time to fill out this form. It will be reviewed by the physician and will become part of your record.

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO MID-MICHIGAN HEALTH CENTERS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information Mid-Michigan Health Centers		
Street Address 214 N West Ave		
City Jackson	State MI	Zip Code 49201
Phone Number 517-784-9189	**PLEASE MAIL RECORDS**	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service from the previous ***TWO YEARS ONLY*** may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, consults, and records sent by other health care providers.

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority:

MID-MICHIGAN HEALTH CENTERS

Patient Consent for Use and Disclosure of
Protected Health Information for Treatment, Payment and Operations

With my consent, Mid-Michigan Health Centers, hereinafter referred to as "This Medical Practice", may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I acknowledge that I have been referred to This Medical Practice's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I understand that I have the right to review This Medical Practice's Notice of Privacy Practices prior to signing this consent form.

This Medical Practice 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 This Medical Practice's designated Privacy Officer at:

Privacy Officer
Mid-Michigan Health Centers
214 N. West Ave.
Jackson, MI 49201

With my consent, This Medical Practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, This Medical Practice may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, This Medical Practice may e-mail to my home or other designated location any items that assist This Medical Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that This Medical Practice restrict how it uses or discloses my PHI to carry out TPO. However, This Medical Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this consent form, I am consenting to This Medical Practice's use and disclosure of 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, This Medical Practice may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Printed Patient's Name Date

_____

Printed Name of Patient or Legal Guardian

MID-MICHIGAN HEALTH CENTERS

PRESCRIPTION POLICY

When you are in need of medication refills, our policy is as follows:

- We ask that you contact us 5 days prior to running out of your medication(s) to allow for review and approval.

- When calling the office, you will be transferred to our Prescription Line to process your request.

- Your request will be reviewed by your prescribing provider, which may take 24-48 business hours for approval.

- Please understand that contacting the office to check the *status* of your request; prior to the 48 hour timeframe, **WILL NOT** expedite the process.

- **Re: Medication Prior Authorizations** - We ask that you understand your prescription plan coverage **thoroughly** (i.e. your plan formulary and coverage policies). You will need to reach out to your individual plan with any questions as we do not have access to those policies and their guidelines or coverage requirements. This will help us to help you, should you need a medication prior authorization. **Please understand that pursuing a medication authorization is a timely process, so your assistance is critical in order to achieve a favorable outcome on your behalf.**

By signing below, I acknowledge that I have read and understand the above policy

_____

Patient Printed Name

_____

Patient Signature

_____

Date

MID-MICHIGAN HEALTH CENTERS

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FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate with Medicare, Blue Cross Blue Shield, Blue Care Network, Priority Health and several commercial insurance plans. If you are insured by a plan that we do not participate with, payment in full is expected at each visit. If you are insured by a plan that we do participate with, but don't have an up-to-date insurance card, payment in full for each visit will be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of Insurance. All patients must complete our demographic/ patient information form before seeing the doctor. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Co-Payments and Deductibles. All co-payments and deductibles MUST be paid at the time of service upon check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit.

Claim Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. At times, your insurance company may need you to supply them with certain information. It is your responsibility to comply with their request. Please be aware that the balance of your claim, as determined by your insurance plan contract, is your responsibility to pay. Your contract benefits are between you and your insurance company; we are not party to that contract. Any disputes that may arise will need to be addressed by the patient or responsible party with their respective insurance plan.

Nonpayment. If your account is over 180 days (6 months) past due, you will receive a letter stating that you have 2 weeks to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency.

Our practice is committed to providing the best care to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. We will be happy to address any questions or concerns you may have.

I have read and understand the payment policy and agree to abide by its guidelines.

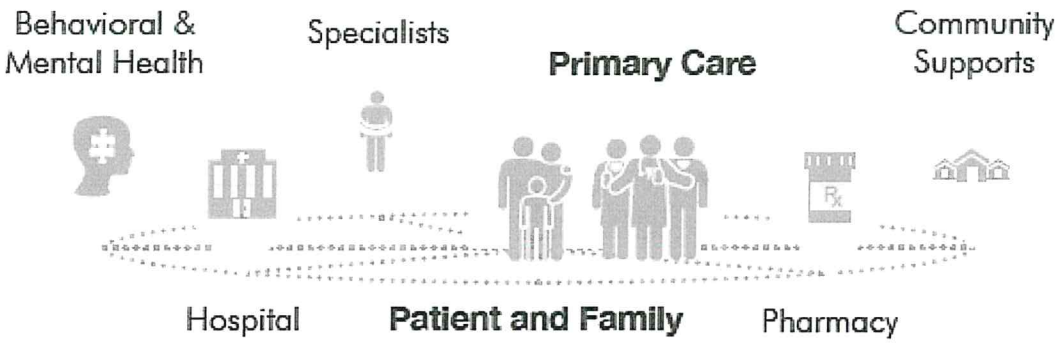
_____ _____

Signature of Patient or Responsible Party Date

214 N. West Ave. • Jackson, MI 49201 • Tel: 517-784-9189 • Fax: 517-784-9657

Be a Partner in Your Health!

A Patient-Centered Medical Home (PCMH) *is a system of care in which a team of health professionals' work together to provide all of your health care needs. You, the patient, are the most important part of a PCMH - take an active role in your health and work closely with us.*



As your PCP here at Mid-Michigan Health Centers, we are committed to co-managing your care with you and other health professionals you may have encounters with

As a member of your healthcare team, I will:

- ***Listen and clearly explain*** your condition in order to help you make an informed decision.
- ***Communicate*** your care plan to vital players in your medical home.
- ***Protect*** your medical information/records.
- ***Schedule*** future appointments and referrals.
- ***Ensure*** you receive necessary test reminders and results.

As a partner in your health, I need you to:

- ***Follow through*** on all appointments.
- ***Learn*** about your insurance coverage.
- ***Tell us what medications*** you are taking and ask for refills when needed.
- ***Follow the care plan*** agreed upon and let us know of any barriers.
- ***Seek advice*** from your PCP before seeing other physicians.

To assist you in managing your health, please note the following:

In the course of providing care, your health information may be shared with other care providers who are involved in your care.

Test Results

All normal test results are communicated via letters within 2 weeks of our receipt of your results. Abnormal test results are communicated via phone calls within 48 business hours of our receipt of your results. If you have not received test results, please call our office directly.

After Hours Care

Emergent: HFA E.R.
Urgent: Med Plus

Community Resources

Resources are available to act as an additional resource in reaching your goals. Please contact the 2-1-1 hotline or a listing of Jackson Health Networks resources at http://www.jacksonhealthnetwork.org

Practice Name: Mid-Michigan Health Centers
Address: 214 N West Ave
City, State ZIP Jackson, MI 49201
Phone Number: 517-784-9189
Practice Hours: Mon-Fri 8am-5pm

MID-MICHIGAN
HEALTH CENTERS

MATT T. ROSENBERG, M.D. • STEPHEN J. ARNTZ, M.D.
ELIZABETH G. ZWICK, P.A-C. • CHANNING M. SMITH, M.D.

MMHC AFTER HOURS CARE POLICY

The purpose of this letter is to educate you, our patient, regarding the most effective use of after hours care options available to you.

If you encounter any health related issues after hours, please call our office at (517) 784-9189. You will then be advised, depending on your medical issue, as to the appropriate level of care to seek.

Following is the information you will hear via our after hours message:

"For life threatening emergent issues such as uncontrolled bleeding, suspected heart attack, difficulty breathing or stroke proceed to Allegiance hospital."

"For non-life threatening issues such as minor wounds, sprains, sore throat or fever proceed to Med-Plus urgent care."

Please remember that urgent care is less expensive and has a shorter wait time than the emergency department at the hospital. Be sure to check with your health insurance carrier when utilizing an urgent care facility to be sure that your visit will be covered.

We hope that this guide will assist you when you are in need of after hours care and thank you for choosing Mid-Michigan Health Centers as your Patient Centered Medical Home.

214 N. West Ave. • Jackson, MI 49201 • Tel: 517-784-9189 • Fax: 517-784-9657