COUNTRY CREEK FAMILY PHYSICIANS

4986 Adams Rd, Suite A
Rochester, MI 48306

Date: _____

PATIENT INFORMATION

Please Print

_____ _____ _____ _____ _____

Last First MI Birth Date Sex Social Security Number

_____ _____ _____ _____

Address City State Zip Code

CONTACT NUMBERS

Please check your preferred contact

- ☐ Cell Phone _____
- ☐ Home Phone _____
- ☐ Work Phone _____

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

RACE

- ☐ Caucasian (White)
- ☐ Asian/Indian
- ☐ Native Hawaiian
- ☐ Native American/Alaska Native
- ☐ Pacific Islander
- ☐ Other

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Other_____

Employer _____

Occupation _____

Email Address _____ Who may we thank for referring you? _____

Would you be interested in receiving information on Advanced Directives? Yes No

INSURANCE HOLDER ☐ Check here if you, the patient, are the responsible party **********

_____ _____ _____ _____ _____

Last First MI Birth Date Sex Social Security Number

_____ _____ _____ _____

Address City State Zip Code

RESPONSIBLE PARTY

_____ _____ _____ _____ _____

Last First MI Birth Date Sex Social Security Number

_____ _____ _____ _____

Address City State Zip Code

EMERGENCY CONTACT

Name_____ Phone_____ Relationship_____

I AUTHORIZE THAT ALL ASPECTS OF MY MEDICAL CARE INCLUDING LAB/TEST RESULTS MAY BE DISCUSSED WITH THE FOLLOWING PEOPLE:
NO ONE BUT MYSELF (PLEASE CHECK IF MEDICAL CARE IS ONLY TO BE DISCUSSED WITH THE PATIENT)

_____ _____ _____

Name Date of Birth Relationship

_____ _____ _____

Name Date of Birth Relationship

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) _____ **DATE** _____

COUNTRY CREEK
FAMILY PHYSICIANS
New Patient History

Patient Name: _____

DOB: _____ Date: _____

MEDICAL HISTORY/MEDICATIONS	☐ SEE LIST		
MEDICATION NAME	DOSE	DIRECTION	FOR WHAT MEDICAL CONDITION

Do you have any other medical problems not listed above?

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING?			
HEALTH MAINTENANCE	DATE/YEAR	LOCATION	
Tetanus Vaccine			
Pneumonia			
Shingles Vaccine			
Influenza Vaccine			
HEALTH MAINTENANCE	**DATE/YEAR**	**LOCATION**	**RESULTS**
Colonoscopy			
Mammogram			
Pap Smear			
Bone Density Test			

Do you currently use tobacco?	☐ Never Used	☐ Former User	☐ Current/Someday User	☐ Current/Daily User
What kind of tobacco?	☐ Cigarettes	☐ Cigars	☐ Chewing Tobacco	☐ Other
At what age did you start smoking?		At what age did you quit smoking?	**Do you consume alcohol? Yes ☐ No ☐** **How much per:** **day_____ week_____ month_____**	
How much tobacco do you use per day?	_____packs per day	_____cans of smokeless tobacco per day		

SURGERIES/OPERATIONS	
DATE	SURGERY/OPERATION

DRUG ALLERGIES	☐ No Drug Allergies
MEDICATION	REACTION

FAMILY HISTORY		
Please list any of your ***IMMEDIATE*** family members that have had any of the following medical issues:		LIVING? YES or NO (If deceased, what age?)
Hypertension (high blood pressure) **Hypercholesterolemia (high cholesterol)** **Diabetes** **Heart Disease/Heart Attack** **Cancer/Type:** _____ **Other:** _____	_____ _____ _____	_____ _____ _____

OUR MEMO OF UNDERSTANDING

Thank you for choosing our Patient-Centered Medical Home medical practice as your home base for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuing and personal medical care. In order for this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

PHYSICIAN AND PATIENT RELATIONSHIP

Both the physician and patient have responsibilities. By listing them, we can better understand the components of a successful relationship between a physician and patient.

We are not attempting to make a written contract. Contracts may mislead patients into expecting a favorable result. Unfavorable results occur with even the best of care.

We can still attempt to describe an optimal physician-patient relationship. It can be described as a series of responsibilities. The patient and physician act in good faith toward a shared goal, the best health of the patient. Let us look as some of these responsibilities.

- **Honesty:** The patient is honest in his or her description of symptoms. The physician is honest in discussing the diagnosis and prognosis.
- **Science:** The physician uses medicine proven by scientific methods. The patient does not demand unproven, dangerous treatment.
- **Diversity:** Each patient is a member of a community and has a heritage of customs and diets. The physician works within the framework of the patient's heritage.
- **Communication:** The physician is clear and straightforward in giving directions. The patient asks questions if he or she does not under the physician.
- **Respect:** The patient and physician try to be respectful of each other's time. The physician provides all the time necessary to provide good care.
- **Fairness:** The physician charges a fair price for his or her services. The patient pays for his or her share of the care.
- **Continuity**: The physician offers reasonable office hours and gives directions for after-hour emergencies. The patient follows the office guidelines in scheduling visits and arranging after-hours care.
- **Referrals:** The physician may refer to specialists or suggest tests that are not done in physician's office. The patient follows his or her health plan guidelines when obtaining these services.
- **Environment:** The patient does his or her best to promote a health environment. The physician considers the interaction between the patient's health and his or her surroundings.
- **Community:** The physician and patient discuss educational and community resources. The patient uses these resources to promote his or her health.
- **Lifestyle:** The patient attempts to follow healthy habits and lifestyles. The physician and patient discuss the patient's lifestyle and its effect on the patient's wellbeing.
- **Disclosure:** The physician presents warnings of possible adverse effects of treatment. The patient gives or withholds consent to accept or reject the offered treatment.
- **Sympathy:** The physician to the patient's medical problems. The patient is sympathetic to the physician's difficult profession.

Over time a trusting relationship can be built between patient and physician. The physician or patient can break this trust by neglecting any of their responsibilities.

Please take the time to carefully read this Memo of Understanding. Kindly sign your name in the appropriate place below. I understand that I may withdraw from the practice at any time.

Physician Signature	Patient/Caregiver	Date

I request payment of authorized medical benefits to be made on my behalf to Country Creek Family Physicians. I authorize any medical information needed to determine benefits payable to be released to my insurance company or its' agent. Further, I understand that any service not covered by my insurance will become my full responsibility, and is due and payable by me. I also certify that the above information is correct.

Signature of Patient/Responsible Party _____ Date _____

PRIVACY NOTICE

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Acknowledgement: I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES.**

Patient Name (please print) _____

Signature of Patient/Responsible Party _____ Date _____

If person representative's signature appears above, please describe personal representative's relationship to the patient.

_____

FINANCIAL POLICY/INSURANCE AUTHORIZATION

Dear Patient:

Thank you for choosing us as your healthcare provider. This document is a summary of our financial policies, and explanation of your responsibilities, and authorizations to bill your insurance on your behalf for services provided to you.

You are responsible for co-payments, deductibles, and services provided which may not be considered a benefit under your policy. All co-pays, deductibles, and unpaid balances are due at the time of service.

Collection/Fees

I understand there is a $25.00 fee for returned checks.

There is a $25.00 charge for appointments that are, "no call, no show." This also applies to any cancellations less than 24 hours prior to my appointment.

All payments are due immediately after receiving the explanation of benefits from any of the insurance companies.

Patient Name **Date**

Signature of Patient **Date**

HIPAA AUTHORIZATION FORM

Please complete all information legibly.

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

Consent to Treat

[ ] I authorize, (onset guardian), to bring my child to Country Creek Family Physicians to be seen by any physician in the office in my place that I cannot be present. I give permission to this guardian to make any necessary medical decisions if needed.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____