LEGACY MEDICAL GROUP

PATIENT IDENTIFICATION INFORMATION/ ADULT MEDICAL HISTORY

Instructions: Please fill out as completely as possible. All information will be kept confidential.

Name_____ **Date of Birth**___/___/___
Last **First** **Middle Initial**

Address_____ **Age**_____ **Sex**_____

Home Phone ( ) _____ **Cell Phone ( ) _____**

Email:_____

EMERGENCY CONTACT PERSON

Name_____ **Relationship _____POA [ ]**

Address_____

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

Email:_____

CURRENT MEDICAL PROBLEMS

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you.

ILLNESS OR MEDICAL PROBLEM	TREATING PHYSICIAN

ILLNESSES AND MEDICAL PROBLEMS

Please mark with an (x) any of the following illnesses and medical problems you have or have had and indicate the year when each the problem started. If you are not certain when an illness started, write down an approximate year.

ILLNESS	X	YEAR	ILLNESS	X	YEAR	ILLNESS	X	YEAR
Eye or eye lid infection	□	_____	Heart murmur	□	_____	Epilepsy	□	_____
Glaucoma	□	_____	Other heart condition	□	_____	Head injury	□	_____
Other eye problems	□	_____	Stomach/duodenal ulcer	□	_____	Stroke	□	_____
Deafness	□	_____	Diverticulosis	□	_____	Convulsions, seizures	□	_____
Bronchitis	□	_____	Colitis	□	_____	Arthritis	□	_____
Emphysema	□	_____	Gout	□	_____	Cancer or tumor	□	_____
Pneumonia	□	_____	Yellow jaundice	□	_____	Bleeding tendency	□	_____
Allergies or asthma	□	_____	Liver trouble	□	_____	Diabetes	□	_____
Tuberculosis	□	_____	Hepatitis	□	_____	Psoriasis	□	_____
Other lung problems	□	_____	Hernia	□	_____	Mental illness	□	_____
High blood pressure	□	_____	Hemorrhoids	□	_____	Other (please indicate)	□	_____
Heart attack	□	_____	Kidney or bladder disease	□	_____	_____	□	_____
High cholesterol	□	_____	Kidney stone	□	_____	_____	□	_____
Arteriosclerosis	□	_____	Prostate problem	□	_____	_____	□	_____
		__	Migraine headache	□	_____	_____	□	_____
					___	___		___

Name_____ **Date of Birth**___/___/___
Last **First** **Middle Initial**

HOSPITALIZATIONS

Please list hospitalizations, if any. Please do not include normal pregnancies.

Year	Operation/Illness	Hospital and City

MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin or cold tablets).

Medication	Dose	How often taken	Medication	Dose	How often taken
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

ALLERGIES AND SENSITIVITIES

List anything that you are allergic to, such as certain foods, medications, dust, chemicals, soaps, household items, pollen, bee stings, etc…, and indicate how each affects you.

Allergic to:	Reaction	Allergic to:	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

SOCIAL/PERSONAL HISTORY

Currently Live: □ Alone □ with family □ with friend(s) □ with significant other

Marital Status: □ Married □ Divorced □ Single □ Separated □ Widowed **Last grade completed in school: _____**

Have you ever been rejected for health reasons by the military, an employer, or an insurance company? □ No □ Yes
If yes, Please explain: _____

Smoking history: Do you currently smoke? □ No □ Yes How much per day? _____ How many Years? _____
Are you a former smoker? □ No □ Yes Do you chew tobacco? □ No □ Yes

Consumption of alcoholic beverages: □ No □ Yes, if so how much _____

Do you use drugs □ No □ Yes, if so Type _____ Frequency _____

Do you exercise regularly? □ No □ Yes, if so how often _____ Do you wear seatbelts: □ No □ Yes

Are there any health risks involved in your job, home environments, or activities? □ No □ Yes, If so please explain:
_____
_____
_____

FAMILY HEALTH HISTORY

Please give the following information about your immediate family.

Relationship	Age if living	Age at Death	Health condition or cause of death
Father			
Mother			
Brother (s)			
Sister (s)			
Spouse			
Grandparent (s)			

SYSTEM REVIEW

Place a mark in the box for each item that you have now or have had in the past and where applicable, please fill in additional information.

General □ Weakness □ Chills □ Fatigue □ Night Sweats □ Change in weight □ Change in appetite □ Change in sleeping habits

Skin □ Itching □ Rash □ Change in color □ Easy bruising

Nervous System □ Headache □ Double vision □ Numbness □ Dizziness □ Muscle weakness □ Loss of coordination

Lungs □ Cough □ Shortness of Breath □ Positive TB test □ Wheezing □ Spitting up blood □ Last chest X-Ray: _____

Heart □ Chest Pain □ Trouble breathing at night □ Easy fatigue □ Palpitations (heart pounding) □ Trouble climbing stairs □ Ankle swelling

Gastrointestinal □ Stomach pain/abdominal pain □ Difficulty swallowing □ Changes in bowel habits □ indigestion/heart burn □ vomiting □ blood in stools

Urinary □ Pain on urination □ Frequent urination □ Difficulty starting to urinate □ Blood in urine □ Previous infection

Eyes □ Glasses/contacts □ excessive tearing □ Eye pain □ blurring or spots □ Last eye exam date: _____

Ears □ Loss or decreased hearing □ Ringing □ Drainage

Nose/throat/sinuses □ Nosebleed □ Hoarseness □ Swelling □ Sore throat □ Post nasal drip

Mouth □ Dentures □ Bleeding gums □ Toothache □ Last Dental exam: _____

Joints & Back □ Pain □ Swelling □ Stiffness □ Deformity

Muscles □ Pain □ Weakness □ Twitching

SIGNS AND SYMPTOMS NOT COVERED ABOVE

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

PATIENT REGISTRATION FORM

INSURANCE INFORMATION

If subscriber is not the patient, please provide the information for that person

Primary Insurance

Name of Insured: _____ DOB:___/___/___

Insurance Name: _____ Policy Number: _____

Group Number: _____

If subscriber is not patient: Relationship _____ *Last 4 of SSN*: _____

Secondary insurance

Name of Insured: _____ DOB:___/___/___

Insurance Name: _____ Policy Number: _____

Group Number: _____

If subscriber is not patient: Relationship _____ *Last 4 of SSN*: _____

Person Responsible for Payment (If other than patient)

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy: _____

Name/address Telephone

PATIENT RECORD OF DISCLOSURE

Telephone Messages: ☐ May leave message with detailed health information ☐ Leave call back number only

Contacts: You allow the person(s) listed below to contact our office to discuss your health-related information. Please designate only **one primary contact** and instruct the designated person to share with other members.

_____

Patient/Guardian Signature **Date**

_____

Physician Signature **Date**

CONSENT FOR TREATMENT

Legacy Medical Group
1460 Walton Blvd, Ste 200
Rochester Hills, MI 48309
Phone: 248-650-1800 / Fax: 248-650-1856

PATIENT NAME_____ DOB___/___/___
Last First Middle Initial

Please read the following statements carefully: Ask any question which will help you understand them. Your signature at the bottom of this form indicates agreement with each statement, and gives us permission to provide series as indicated below:

I authorize legacy Medical Group to provide treatment to me or my legal dependent. I understand that treatment does require a mutually agreed upon plan of service and that my participation in this plan is essential.

I understand that through the course of treatment, my physician will assist me in understanding procedures, possible risks and purposes of treatment. I understand that I may withdraw my consent to treatment at any time, but I will notify Legacy Medical Group of my intent to do so. I further understand that I must comply with the treatment plan in order to receive continued services from the treating physician.

I understand that information will be made available to me regarding my rights and responsibilities. I will be given the opportunity to ask questions about the policies and services of Legacy Medical Group and I will receive a copy of this signed consent form if I so request.

Consent for treatment with the use of prescription medications (as documented in my medical record)

My physician has informed me that he recommends that I receive the medication(s) listed in my medical record for the treatment of my symptoms. My physician has explained to me the risk of possible side effects. Although my physician has discussed the most common side effects associated with this/these medication(s) I understand I may experience other side effects. I further understand that I should promptly contact my physician or other member of this staff if there are any unexpected changes in my condition. I understand that I may not be compelled to take this/these medication(s) and that I may request it to be discontinued at any time. However, I recognize that if I stop the medication, I may experience serious side effects and therefore I should consult with my physician before making such a decision. I also understand that although my physician believes that this medication(s) will help me, there is no guarantee that it will be effective in the treatment of my particular symptoms. On this basis I authorize my physician to administer this/these medication(s) at such intervals as he prescribes.

_____

Patient/Guardian Signature **Date**

_____

Physician Signature **Date**

FINANCIAL RESPONSIBILITY POLICY / INSURANCE AUTHORIZATION

Legacy Medical Group
1460 Walton Blvd, Ste 200
Rochester Hills, MI 48309
Phone: 248-650-1800 / Fax: 248-650-1856

PATIENT NAME: _____ DOB____/____/___
Last First Middle Initial

Thank you for choosing Legacy Medical Group as your health care 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 may be 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 time of visit, or by date of statement. **Your insurance may deny claims for a variety of reasons:**

- The services provided may not be a benefit of your health insurance policy or may not be covered when provided by our office (e.g., mental health services, laboratory, etc.).
- You may have exhausted your insurance benefits for the services provided.
- MEDICAL NECESSITY or MEDICALLY NECESSARY generally means a determination based upon criteria and guidelines developed by your insurance carrier in consideration of generally accepted standards and practices. **The services must meet all of the following criteria:**
  - A) It is generally accepted as necessary and appropriate for the patient's condition, given the symptoms, and is consistent with the diagnosis; and
  - B) It is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness and is not mainly for the convenience of the member or physician; and
  - C) It is reasonably expected to improve the patient's condition or level of functioning or, in the case of diagnostic testing, results are used in the diagnosis and/or managements of the patient's care.

Collections / Fees:

- I understand there is a fee of $25 for returned checks.
- There may be a $25 charge for appointments that are "No Show, No Call". This applies to any cancellations less than 24 hours prior to my appointment. If you arrive more than 20 minutes late for your appointment you may be charged a $25 fee and asked to reschedule your appointment. For home visits that are "No Call, No Show", a fee will be assessed that is equal to the Medicare allowed amount for a level 3 visit.
- A fee of $15 may be added to your balance for all unpaid balances and copays due at time of visit.
- In the event that your unpaid balance needs to be sent to collections, you will be responsible for all collections fee, attorney fees, and any other fees incurred in the collections process.
- **Facility Patients:** For all services requiring a technician to be present at the facility, there is a fee of $25. This charge will not be billed to the your insurance, and applies to diagnostic testing, therapeutic injections (B12 shots), and lab draws. In addition, a pick-up fee of $35 will be assessed for all STAT (or urgent) testing and pick-ups that can not be handled during our regular schedule at your facility. Generally, urine and stool samples are valid only up to 24 hours, thereby necessitating a need for immediate pick-up and processing.

_____ _____ _____ _____
Signature of Patient / Responsible Party **Date** **Signature of Witness** **Date**

Legacy Medical Group
1460 Walton Blvd., Suite 200
Rochester Hills, MI 48309
Phone: 248-650-1800
Fax: 248-923-2850 (Records)

Brian T. Gietzen, MD
Ameena T. Kazi, MD
Juan J. Rhoades, ANP-B
Bennett H. Lee, PA-C
Kelsey M. Walsh, PA-C
Lucienne Zenieh, MD

AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS INFORMATION

Physician we are requesting medical information from: _____

I authorize the custodian of records to disclose/release my medical information.

☐ All records ☐ X-ray/radiology ☐ Lab/pathology records ☐ Other (describe)_____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. I understand that after custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Name _____ Phone _____ DOB _____

Signature of Patient _____ Date _____

Or

Signature of Guardian _____ Date _____

Printed Name of Guardian _____

PLEASE INCLUDE A COPY OF YOUR POWER OR ATTORNEY OR GUARDIANSHIP FORM, IF AVAILABLE.

FOR PHYSICIAN OFFICE: *Please mail records instead of faxing, if over 50 pages. If you do not have any records for this patient, please provide us with a brief explanation. This authorization expires one year after it has been signed.*

Acknowledgement of Receipt of Notice of Privacy Practices

Legacy Medical Group reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices for Legacy Medical Group.

Signature of Patient **Print name** **Date**

If Patient is a minor or an adult who is unable to sign this form a Patient Representative must sign for the Patient below:

Signature of Patient Representative **Relationship to Patient** **Date**

Or

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attempt to obtain acknowledgement: An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____

The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgement
- ☐ Other _____

Name of Patient **Name of Staff Member** **Date**

Legacy Medical Group: 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 carefully**

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Legacy Medical Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning our medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information
5. Right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on you next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to you records by contacting one of our receptionists or our Privacy Officer.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after April 14, 2003. Revised on March 3, 2016.