Saginaw Valley Family Care
5200 State St.
Saginaw, MI 48603
P: 989-793-4250 F: 989-793-6880

PATIENT INFORMATION_____(Please Print)

Patient's Name_____

Address_____

City,State,Zip_____

Home Phone_____ **Cell #**_____**Work #**_____**Ext.**_____

Race ____Asian ____Black ____White ____Hispanic ____Native ____American/Eskimo ____Other

Ethnicity _____Hispanic or Latino _____Not Hispanic **Language** _____English _____Spanish **Gender:** Male: _____ Female: _____Preferred: _____

SSN_____ **Date of Birth** MM/DD/YYYY_____

E-Mail Address_____

Employer Name_____

Employment Status_____Full-Time_____Part-Time_____Unemployed_____Self-Employed_____Retired

Marital Status _____ Single _____Married _____Widowed _____Divorced

Name of Spouse_____**Phone**_____**D.O.B.**_____

Emergency Contact_____**Relationship**_____
Home Phone _____**Cell #**_____**Work #**_____**D.O.B**._____

Emergency Contact_____**Relationship**_____
Home Phone_____ **Cell #**_____**Work #**_____**D.O.B**._____

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE AT THE FRONT DESK

Saginaw Valley Family Care participates with a variety of health care plans (contact your insurance company directly to see if we partner with your insurance plan). As a courtesy to our patients, our office will submit claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day the service is rendered or paying in full if we do not participate with your health care plan.

I understand that my insurance policy is a contract between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time services are rendered. I agree to be financially responsible for all costs incurred in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by this office, whether conducted in this office or elsewhere which are not otherwise paid by my insurance.

Some information contained in my patients record are necessary for the payment of insurance benefits without regard to any limitation placed on dates, history of illness or diagnostic and therapeutic information. I hereby authorize Saginaw Valley Family Care or its designee to bill and release to my insurance company and/or third party payer(s) and/or external review agency.

Guarantor Signature_____ Date_____

(Responsible Party)

Saginaw Valley Family Care

PATIENT CENTERED MEDICAL HOME (PCMH) Patient / Provider Agreement

Good communication between patients and physicians is the key to better outcomes. My staff and I are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.
Our Responsibilities to You:

- Respect you as an individual – we will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation or genetic information
- Respect your privacy – your medical information will not be shared with anyone else unless you give permission or as required by law
- Provide the best possible treatment and advice based on current medical evidence – we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
- Manage your health status, including well person/preventive care as well as treatment for acute and chronic diseases
- Provide you timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed. What We Ask of You:

- Ask questions and share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your doctor about any changes in your health and well-being
- Take your medicine as ordered and follow your doctor's advice-if you are unwilling or unable to do so, be honest with the doctor
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor first with all problems, unless you have a medical emergency
- Have a clear understanding of your doctor's expectations, treatment goals and future plans at the end of your visit.

PLEASE NOTE: Our office is open 8:30 a.m. to 5 p.m. Monday through Thursday. When the office is closed, you can reach one of our providers by dialing our office number, to address medical issues, which cannot wait until regular office hours. It is important that you keep all scheduled appointments and notify us sufficiently in advance if you need to cancel or reschedule appointments. Urgent or Emergent Care: Please attempt to call the office before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

Patient Name: _____ Date of Birth: _____

Signature: _____ Todays Date: _____

Relationship to Patient: _____

If signed by Legal Guardian/Representative

Saginaw Valley Family Care
5200 State St.
Saginaw, MI 48603
P: 989-793-4250 F: 989-793-6880

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provide information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The undersigned patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent

Name of Patient (Printed)	Date of Birth	Date

Signature of Patient or Legal Guardian/Representative

Printed Name of Patient or Legal Guardian/Representative

Relationship to Patient, if signed by, Legal Guardian/Representative

Saginaw Valley Family Care

Release of Information Authorization

I hereby give permission for the following person or persons listed below (example: parents, spouse, children, relatives, significant other, etc.) to receive information regarding my medical care (example: appointment times, test results, medication, etc.) You may add or delete anyone at any time. This permission will be solely used by Saginaw Valley Family Care.

IF THE INDIVIDUAL IS NOT LISTED BELOW, WE CANNOT GIVE OUT ANY INFORMATION TO THEM.

_____ I WANT the following people to be able to discuss information regarding my medical care:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

_____

_____ I DO NOT WANT anyone, other than myself, to be able to discuss information regarding my medical care.

_____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

(If signed by Legal Guardian, or Representative)

Name:_____Date of Birth:_____Today's Date_____

Medical History

Asthma	YES	NO
Anxiety	YES	NO
Angina Pectoris	YES	NO
Abnormal Stress Test	YES	NO
Tonsillectomy	YES	NO
Hysteroscopy	YES	NO
Endo Biopsy	YES	NO
Cyst Removal	YES	NO
Colonoscopy (Abnormal)	YES	NO
Cardiac Cath	YES	NO
Dilatation and Curettage	YES	NO
Sexually Active	YES	NO
Birth Control/Protection	YES	NO
Partner Type	MALE	FEMALE

Smoking	YES	NO
Cigarettes/Pipe/Cigar/Hookah/ Nicotine/Vapors/Snuff/Chew		
Packs Per Day		
Number of Years		

Alcohol	YES	NO
Drinks per Week		

Drug Use	YES	NO
IV/Prescription Drugs/Heroin Marijuana/Methamphetamines/Cocaine		

Family Medical History (P-Father) (M-Mother)

Cancer:	Mother	Father	P/M Grandmother	P/M Grandfather	Sister	Brother
Heart Disease:	Mother	Father	P/M Grandmother	P/M Grandfather	Sister	Brother
Hypertension:	Mother	Father	P/M Grandmother	P/M Grandfather	Sister	Brother
Depression:	Mother	Father	P/M Grandmother	P/M Grandfather	Sister	Brother
Asthma:	Mother	Father	P/M Grandmother	P/M Grandfather	Sister	Brother

Surgical History

Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:

Social History

Advance Directives	YES	NO	Do you exercise	YES	NO
Need for an Interpreter	YES	NO	Any Tattoos	YES	NO
Any Guns in The Home	YES	NO	Any Piercings	YES	NO
Do You Wear a Bike Helmet	YES	NO	Breast Self-Exam	YES	NO
Have You Ever Been Abused	YES	NO	Testicular Self-Exam	YES	NO
Working Smoke Alarms in the Home	YES	NO	Do You Have a Legal Guardian	YES	NO
Do You Wear a Seat Belt	YES	NO			
Do You Use Sunscreen	YES	NO			

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best past medical care by answering the questions below year? Which of the following drugs have you used in the

- ☐ methamphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I II III IV

Patient Health Questionnaire-2 (PHQ-2)

Patient Name_____ Date _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____*0*_____*+*_____*+*_____*+*_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____