DEMOGRAPHICS FOR (Patient Name):

Address
City:
State:
ZIP:
DOB:
Age:
Gender:

Primary Phone:
Alternate:
Email:

Race:
Ethnicity:
Language:

GUARANTOR for Patient Name:

Address:
City:
State:
ZIP:

Primary Phone:
Social Security:
DOB:

EMERGENCY CONTACT:

Last Name:
First Name:
MI:
Address:
City:
State:
ZIP:
Primary Phone:
Alternate Phone:
Relationship to Patient:

PRIMARY INSURANCE:

Carrier:
Address:
ID :
Group Number:
Subscriber:
Subscriber DOB:

SECONDARY INSURANCE:

Carrier:
Address:
ID :
Group Number:
Subscriber:
Subscriber DOB:

PHARMACY INFORMATION:

NAME:
ADDRESS ID:

I HAVE READ AND VERIFIED THAT ALL THE ABOVE INFORMATION IS CORRECT AS OF TODAY'S DATE

_____ _____

Signature Patient/legal guardian

Date

Notice of Privacy Practices

Uses and disclosures:

Treatment: Your health information may be used by staff members or disclosed to other health care 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 staff members. Information sharing may be through the mailing or faxing of written medical Information or through electronic sharing.

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 Little Traverse Primary Care. 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 to support government audits and inspections, to facilitate law-enforcement investigations, 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.

Health Information Exchanges: Your provider records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges. This organization participates in the Great Lakes Health Connect (GLHC) information network. GLHC has rules regarding how health information can be accessed through GLHC, and limits on use or disclosures of that information.

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 or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

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

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Little Traverse Primary Care Duties: We are required by law to maintain the privacy of your protected health information and to provide you this notice of privacy practices. We also are 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. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect your protected health information be sub-mitted in writing. You may obtain a form to request access to you records by contacting **Victoria Anderson – Privacy Official**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

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 **Victoria Anderson – Privacy Official.**

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.

Contact Person The name and address of the person you may contact for further information concerning our privacy practices:

Victoria Anderson– Privacy Official
Little Traverse Primary Care
8881 M-119
Harbor Springs, MI 49740
(231)347-5400

Effective Date: This notice is effective on or after April 14, 2003.

Acknowledgement of Receipt of Privacy Notice: I have been presented with a copy of the Little Traverse Primary Care's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice.

Patient/Guardian Signature: _____ Date: _____

_____ DOB: _____

Print Patient Name

PATIENT HEALTH HISTORY

Patient Name:

Date of Birth:

MEDICATION ALLERGIES & REACTIONS:	OTHER ALLERGIES & REACTIONS:

CURRENT MEDICATIONS (prescribed and over-the counter, add another sheet if necessary)**:**

Bring all medication/supplements, in their original containers, to your appointment

Medication	Dosage	How Often	Why are you taking this medication?

Current & Past Medical Problems	Past Surgeries with dates

Date of your last:				Immunization Dates:
Pap smear:	normal:	□Yes	□No	Tetanus:
Mammogram:	normal:	□Yes	□No	Pneumovax:
Colonoscopy:	normal:	□Yes	□No	Flu:
Bone Density:	normal:	□Yes	□No	

Tobacco Use (check one):

□ Never □ Former □ Current If current Type: How Much:

Alcohol Use:	**Caffeine Use:**
□ No □ Yes How Much:	□ No □ Yes How Much :

Substance Abuse:

□ No □ Yes If yes Type: How Much:

Family History: Mother Living? □Yes □No Father living? □Yes □No

Anyone diagnosed with:

"X"=Yes	Mother	Father	Sibling	Extended family member, (mom's mother, dad's father, etc)
Breast cancer				
Colon cancer				
Hypertension				
Diabetes				
Stroke				
Heart Attack				

Little Traverse Primary Care
Assignment of Benefits

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage and assign Little Traverse Primary Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance and liability/work compensation/auto claim submissions.

Patient/Guardian Signature: _____

Today's Date: _____

Print Patient Name: _____

Patient Birthdate: _____

Little Traverse Primary Care
Release of Billing & Payment Policy

Payment on Date of Service:

Our priority is to provide you, as our patient, with the highest quality of medical care at the lowest possible cost.

- Patients are expected to pay office-related charges and co-payments the day of your appointment.
- We accept cash, Debit Cards, personal check, Visa, MasterCard, Discover and American Express.

Credit Policy:

In an effort to provide you with necessary medical care, we do offer payment plans to assist with resolution of a balance on your account:

- Unpaid balances will be billed monthly and are expected to be paid in full within 30 days, UNLESS prior payment arrangements have been made with our **Billing department (231-348-3808)**
- Accounts with an unpaid balance over 30 days old, will be asked for payment at every scheduled appointment
- All outstanding balances are subject to 1.5% monthly (18% annual) finance charge

Self-Pay Patients:

- 5% cash discount available (in lieu of insurance/patient billing is available to all patients)
- $100 deposit will be required prior to appointment
- Balance will be collected or refunded at check-out

No-Show/Cancelation Policy:

- Presenting more than 5 minutes late for scheduled appointment, at the discretion of the provider, you may be asked to reschedule
- 24-hour cancellation is required for all scheduled appointments. Failure to give 24-hour notice, unless extenuating circumstances, will result in a $118.00* fee.
- 1st "no show", letter with a copy of missed appointment policy will be sent via mail;
- 2nd "no show" will result in a letter being sent and a $118.00* charge billed to patient;
- ALL "No show" – Annual Wellness/Physical/Well Child visit will result in $172.00* fee.
- Continued disregard for Providers schedule may lead to discharge from LTPC.

*Fees subject to change, cannot be billed to insurance, will be billed directly to guarantor

$25.00 fee will be charged for:

- returned check due to insufficient funds or account being closed
- stop payment has been placed on said check
- any denial of payment from your financial institution

Delinquent Accounts:

- Accounts with unpaid balance over 90 days old will be considered delinquent
- Missing payments through a pre-arranged payment plan will be considered delinquent
- Delinquent accounts will be referred to a collection agency
- Payment in full will be required to schedule or keep a scheduled appointment once referred to collection agency
- All outstanding balances are subject to 1.5% monthly (18% annual) finance charge

Additional Fees:

- An additional fee will be charged for services provided during the regularly scheduled evening hours 5 pm and weekends.

_____ _____
Responsible Party/Guarantor Signature Date

_____ _____
Patient Name Date of Birth

AUTHORIZATION TO LEAVE VOICEMAIL MESSAGE

IMPORTANT: All blanks **MUST** be filled in

Patient Name:	Birthdate:
Address:	Phone:
City/State	Zip code:

I, patient or legal guardian, hereby authorize LITTLE TRAVERSE PRIMARY CARE to verbally leave detailed, personal health information by utilizing the voicemail on the phone numbers listed below:

1. _____
   Phone number

2. _____
   Phone number

TIME PERIOD: (Circle one) ***INDEFINITE*** ***1 YEAR*** ***SPECIFIC TIME PERIOD***: _____

Specific Information approved to disclose:

This authorization allows for verbal messages to be left for any and all non-critical health information with the **EXCLUSION** of psychiatric consults and mental illness, developmental disabilities, alcohol and drug treatment, any Communicable disease and infection information as defined by Statue and Michigan Department of Public Health Rules.

I understand, it is my responsibility to notify Little Traverse Primary Care, in writing, should I wish to CHANGE ONE OR MORE, of the telephone numbers listed above.

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

- If the patient is 18 years of age or older, the patient must sign and date form
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian/Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- The patient is under 18 and I am the **parent** or **legal guardian** (circle one) signing and dating this form.

_____ _____
Patient/Guardian/Legal Representative Signature Date

_____
Printed name of signing patient **IF NOT PATIENT**

AUTHORIZATION FOR EXCHANGE OF PATIENT INFORMATION

YOU give permission, to the person listed below to access medical history and ability to contact us on your behalf.
For example: spouse, family member or friend

IMPORTANT: All blanks **MUST** be filled in

Patient Name:	Birthdate:
Address:	Phone:
City/State	Zip code:

I authorize Little Traverse Primary Care to exchange information with:

Name	Birthdate:
Address:	Phone:
	Relationship to Patient:

Specific Information approved to disclose:

Initial the following:

_____ ANY/ALL RECORDS with the **exception** of:

_____ Communicable disease and infection information as defined by statue and Michigan Department of Public Health Rules.
_____ Alcohol and/or Drug abuse treatment protected under regulation in 42 Code of Federal Regulations, Part 2.

_____Mental health, psychological treatment records and social services information, including communication made by me to a social worker or psychologist.

____ Birth Control Treatment

TIME PERIOD: (Circle one) ***INDEFINITE*** ***1 YEAR*** ***SPECIFIC TIME PERIOD***: _____

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

- If the patient is 18 years of age or older, the patient must sign and date form
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian/Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- The patient is under 18 and I am the **parent** or **legal guardian** (circle one) signing and dating this form.

_____ _____
Patient/Guardian/Legal Representative Signature Date

_____
Printed name of signing patient **IF NOT PATIENT**