Melvindale Family Urgent Care
3805 Oakwood Blvd. Melvindale, MI 48122
P. 313-386-8550 F. 313-436-5055

Name: (Last,First) ____

Social Security Number:______________________ **Date of Birth:** ____/_____/_____ **Sex: F - M**
Marital Status: S- M- D- SEP **Race:** ____

Address: ____
City:____________________________ **State:**_________________ **Zip:**______________________
Home Phone: __________________________ **Cell Phone:** __________________________________
Parent/Guardian (if under 18)____
Relationship: _____________ **SS#** _____________________**Email** ____________________________

Primary Care Physician: _________________________ **Phone Number:** _______________________
Pharmacy Name:________________________________ **Phone Number:** _______________________
Emergency Contact:_____________________________ **Phone Number:** _______________________

Pharmacy Name: ____
Address:_____________________________________ **City:** __________________
State:______________ **Zip:**____________________

Required Payments: Any Copays required by Insurance must be paid at the time of service
Returned checks: there is a $25.00 fee for any checks returned by your bank.

Assignment of Insurance Benefits
I hereby authorize direct payment of surgical/medical benefits to Melvindale Family Urgent Care. I understand that I am financially responsible for any balance not covered by my insurance.
Authorization to Release Information
I hereby authorize Melvindale Family Urgent Care to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
Medicare-Medicaid
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
If we are unable to verify your insurance, payment for services are due before services are rendered. Melvindale Family Urgent Care will reimburse the amount rendered by the insurance company. If your account is sent to a Collection Agency, a 30% processing fee will be added to each new dollar amount sent to collections.

This is an agreement between (Melvindale Family Urgent Care)

Effective date: Once you have signed this agreement ,you agree to all the terms and conditions herein and the agreement will be in full force and effect.

Patient Name:____**Responsible Party**______________________

PatientSignature:_______________________________________**date**____________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of MELVINDALE FAMILY URGENT CARE We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION (“PHI”) PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:
• Your past, present, or future physical or mental health or conditions,
• The provision of health care to you, or
• The past, present, or future payment for your health care

HOW WE MAY USE AND DISCLOSE YOUR PHI We may use and disclose your PHI in the following circumstances:

• **Treatment**. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

• **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

•**Health Care Operations**. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

•Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

• **Minors.** We may disclose the PHI of minor children to their parents or guardians unless law otherwise prohibits such disclosure

• **Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.

•**To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

• **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

• **Public Health Responsibilities.** We will disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

• **National Security.** The health information of Armed Forces Personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

YOUR PRIVACY RIGHTS AS OUR PATIENT

• **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

• **Request Amendments**. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the
right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy
Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your
request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may
prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

• **Accounting of Disclosures.** You have the right to ask for an “accounting of disclosures,” which is a list of the disclosures we made of your
PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of
disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the
reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs
are incurred.

• **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

• **Complaints** If you believe your privacy rights have been violated, you may file a complaint with the **Melvindale Family Urgent Care** Privacy Officer, at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services.

HOW TO CONTACT US

MELVINDALE FAMILY URGENT CARE
3805 OAKWOOD BLVD. MELVINDALE, MI 48122
(313) 386-8550 FAX: (313) 436-5055

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
NOTICE TO PATIENT:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

The patient refused to sign.
Due to an emergency situation it was not possible to obtain and acknowledgment.
We were not able to communicate with the patient.
Other (Please provide specific details)

____
____

______________________________ ______________________________
Employee Signature Date

GENERAL CONSENT TO TREATMENT

1. **Consent to: Melvindale Family Urgent Care**

   I request and authorize the type of facility services checked above as my physicians assistants or designees, (collectively called "the physician") advise. These include routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs and routine medical care. I understand that in emergencies it may be advisable to expand or deviate from the services listed here in order to preserve my life or health. I consent to these expanded services and procedures. I understand that the medical personnel care for me according to the physician's instructions.

2. **Consent to Testing and Disposal of Bodily Fluid Tissue**

   I understand that Melvindale Family Urgent Care may perform non-diagnostic laboratory tests with specimens of blood, urine, and other bodily fluids/tissues that are withdrawn from me for diagnostic purposes, and the Melvindale Family Urgent Care may dispose of these specimens as it chooses.

3. **Release of Information**
   I authorize Melvindale Family Urgent Care to release all information from my entire medical record, including:
   - Information about Human Immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC).
   - Substance abuse treatment information protected by 42 Code of Federal Regulations Part 2
   - Psychological and social services information including communications made by me to a psychologist or social worker.
   - Any health care facility or physician to which I am referred or transferred for continuity of care.
   - Any independent auditors or review retained by any third party payor, private health insurer or employer providing health insurance benefits to me so that these independent auditors can analyze Melvindale Family Urgent Care charges.

These release authorizations shall be effective only as long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at an earlier time unless the Melvindale Family Urgent Care has already released information in reliance upon it. I also agree that the information in my record may be used for Melvindale Family Urgent Care quality review purposes.

Patient or Parent/Guardian Name: (please print) ____

Patient or Parent/Guardian signature: _______________________________ **Date:** ________________

AUTHORIZATION OF MEDICAL INFORMATION RELEASE

DATE: ______________________

I, ______________________________, authorize **Melvindale Family Urgent Care** to release my medical information to myself and only those listed below:

1. ________________________ Relationship _____________________
2. ________________________ Relationship _____________________
3. ________________________ Relationship _____________________
4. ________________________ Relationship _____________________

Signature: ____

This form is valid 1 year from the date signed and must be renewed on a yearly basis.

It is your responsibility to notify our office of any change you want made to this form