3925 Fortune Blvd. Suite 2, Saginaw, MI 48603

Family Medicine
Bassam Afaneh, M.D.

Welcome to our Office

Appointments:

Appointments may be made Monday through Friday by calling 989-341-5078. Please arrive on time for your scheduled appointment. New patients, we ask that you arrive 15 minutes prior to your appointment. Patients who arrive late may have to reschedule or be worked in depending on provider availability. If you are unable to keep your appointment, please call us at least 24 hours in advance of your appointment. If you cancel within 24 hours or no show for your appointment, there will be a $50 charge.

Office Hours:

The office is open Monday through Friday 8 a.m. to 8 p.m. and Saturday through Sunday 10 a.m. to 4 p.m. On inclement weather days, please call our office before your appointment. Your safety is our concern.

Prescriptions and Refills:

Prescriptions and refills are only issued during regular business hours. If you need refills, please inform us at your visit. If you call, please allow 72 hours for refills.

Fees, Payment Policy, and Insurance:

Co-pays are expected at the time of service. There will be a $25 charge for all returned checks. It is your responsibility to know what services are covered on your insurance plan. If you have questions regarding billing, please contact MI Billing Company at 989-459-2300.

Minor Patients:

A parent or guardian must accompany a patient under the age of 18. Unaccompanied minors will only be treated if they have a written note from their parent or guardian.

Lab Billing:

Laboratory tests not performed by MI Health Clinics are sent to LabCorp for analysis and are billed directly through them.

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PATIENT REGISTRATION

Today's Date:_____

Patient First Name:_____ Patient M.I.:_____ Patient Last Name:_____

Preferred Name:_____ Email:_____

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

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

DOB:_____ Age:_____ Assigned Gender:_____ Preferred Gender:_____

Ethnicity (choose one):
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Unknown
- ☐ Prefer not to answer

Race (choose one):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian
- ☐ Other
- ☐ Unknown
- ☐ Prefer not to answer

Preferred Language:_____

PARENT OR RESPONSIBLE PARTY (If different from patient)

Patient First Name:_____ Patient M.I.:_____ Patient Last Name:_____

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

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

DOB:_____ Age:_____ Sex: ☐ Male ☐ Female ☐ Prefer not to mention

INSURANCE INFORMATION (Please present insurance card at time of check-in)

Primary Insurance Name:_____ Insurance Address:_____

Name of Insured:_____ Insured ID#:_____ Insured SSN:_____

Group #:_____ Insured DOB:_____ Employer Name:_____

Employer Address:_____ Employer Phone #:_____

Relationship of patient to the Insured:_____

Pharmacy of Choice:_____ Phone #:_____

Referred by:_____

Primary Care Physician:_____

I have read and understand the financial and office policy of the practice and I agree to be bound by its terms. I hereby authorize Michigan Health Clinics, PC to collect financial information arising from my treatment. This includes, but is not limited to, hospital and laboratory services. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient/Responsible Party Signature:_____ Date:_____

Please print the name of the patient:_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient/Responsible Party Signature:_____ Date:_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected at the time of service in some instances, prior to your visit. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Deposits may be required prior to scheduling certain procedures. Delinquent accounts will be charged an administration fee of $50. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Responsible Party Signature:_____ Date:_____

HIPAA Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time.

May we call your home or other alternative location and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items, and any calls pertaining to your clinical care, including laboratory results among others?

☐ Yes ☐ No If yes, phone number to call:_____

May we contact you at work and leave a message to call our office back?

☐ Yes ☐ No If yes, phone number to call:_____

*Our office will mail benign results to the patient. These results are in the form of a postcard addressed to the patient. Unless told otherwise, these results will be mailed to your home address. Please notify our office if you want these results mailed to an alternate address.

Do we have your permission to talk to family members or other individuals?

☐ Yes ☐ No If yes, please provide the names, phone numbers, and relation to you:

By signing this form, I hereby give my consent for MI Health Clinics, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I acknowledge that I have received or have been given the opportunity to receive a copy of the MI Health Clinics, PC Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

Patient First Name:_____ Patient M.I.:_____ Patient Last Name:_____

Patient/Responsible Party Signature:_____ Date:_____

Note: This form does not authorize us to release actual medical records to you or your representative(s). An authorization for the release of medical records is available upon request. A signed authorization must be updated every 12 months.

Notice and Consent of Communication via Text / Email

Notice: Text messaging / email is not a secure form of communication. There is a risk that any individually identifiable health information and other sensitive or confidential information that may be contained in a message may be misdirected or intercepted by unauthorized third parties. If you wish to use this form of communication, you may consent to receive text messages and email from the MI Health Clinics regarding your services.

Consent: Please read the following and sign below to acknowledge your consent to communication via text message / email.

I understand and accept the risk of sending and receiving information from MHC via text message / email and consent to use of this form of communication. I understand that I can withdraw my consent in writing at any time.

Signature:_____ Date:_____

Authorized Phone Number:_____

Authorized E-Mail Address:_____

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Authorization for Records Release

Patient First Name:_____ Patient M.I.:_____ Patient Last Name:_____

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

DOB:_____ Phone Number:_____ Email:_____

I authorize and request that the following organization DISCLOSE my protected health information:

_____

I authorize that my protected health information should be DISCLOSED TO the following organization or individual:

- ☐ _____
- ☐ Self
- ☐ Individual/Company/Organization:_____
  Street Address:_____
  City/State/ZIP:_____
  Phone Number:_____ Fax Number:_____

The type and amount of information to be disclosed:

☐ Consultation Report(s):_____ ☐ Discharge Summary:_____

☐ History & Physical(s):_____ ☐ Emergency Record(s):_____

☐ Laboratory Result(s):_____ ☐ Operative Report(s):_____

☐ Imaging Report(s):_____ ☐ X-Ray Film(s):_____

☐ Newborn Report(s):_____

☐ Entire Record or Abstract for:_____

☐ Other:_____

☐ Office Notes:_____

Indicate the format in which you would like to receive your requested information:

_____ _____

Signature of Patient or Legally Authorized Representative *Date/Time*

_____

Printed Name of Patient or Legally Authorized Representative

_____ ☐ Photo ID Verified

Staff Signature

Relationship to Patient:
- ☐ Spouse
- ☐ Parent
- ☐ Next of Kin/Executor
- ☐ Legal Guardian
- ☐ DPOA for Healthcare

If you are requesting medical records for someone other than yourself, you may be required to provide documentation that you have a legal right to do so.

Patient Self History

Patient Name:_____ DOB:_____

Preferred/Previous Name(s):_____ Preferred Gender Pronouns:_____

Who is your primary care provider(physician, physician assistant or nurse practitioner)?:

_____

Please place a mark in the box next to any of the following that you have:

Yes	No		Not Received or Unsure	Result/Date Received	
☐	☐	Smoke? Packs Daily:_____ Years?:_____			
☐	☐	Chew tobacco?			
☐	☐	Drink alcohol? #Drinks daily:_____			
		#Drinks weekly:_____			
☐	☐	Use street drugs?			
☐	☐	Do you wear a seatbelt?			
		Do you have difficulty:			
☐	☐	Reading			
☐	☐	Seeing			
☐	☐	Hearing			
☐	☐	History of emotional, physical, or sexual abuse?			
☐	☐	Do you use sunscreen?			
☐	☐	Have you ever had suicidal thoughts or attempted suicide?			
☐	☐	Do you feel safe at home?			
☐	☐	Do you live alone? If no, who do you live with?			
		_____			
			☐	☐	Tetanus/Diptheria
			☐	☐	Tetanus/Diptheria & Pertussis
			☐	☐	Pneumonia
			☐	☐	Meningitis
			☐	☐	Cervical Cancer (Gardasil)
			☐	☐	Flu
			☐	☐	Hepatitis A
			☐	☐	Hepatitis B
			☐	☐	Shingrix
			☐	☐	Chicken Pox Disease or Vaccine
			☐	☐	Colonoscopy
			☐	☐	Mammogram
			☐	☐	Pap Smear
			☐	☐	PSA (Prostate cancer blood test)

Occupation:_____

Health History: Mark the box to indicate which of the following are now or have been a problem:

Yes	No		Yes	No		Yes	No	
☐	☐	Skin rash	☐	☐	Mitral valve prolapse	☐	☐	Stomach ulcers
☐	☐	Open sore	☐	☐	Heart murmur	☐	☐	Diarrhea
☐	☐	Glaucoma	☐	☐	Rheumatic fever	☐	☐	Constipation
☐	☐	Cataracts	☐	☐	Palpitations	☐	☐	Lupus
☐	☐	Asthma	☐	☐	Pacemaker/defibrillator	☐	☐	Gallbladder disease
☐	☐	Emphysema/COPD	☐	☐	Atrial fibrillation	☐	☐	Gastric reflux disease
☐	☐	Chronic cough	☐	☐	Congestive heart failure (CHF)	☐	☐	Low blood sugar
☐	☐	Use oxygen at home	☐	☐	Swelling in feet/ankles	☐	☐	Diabetic
☐	☐	Tuberculosis	☐	☐	High blood pressure	☐	☐	Thyroid problems
☐	☐	Sleep apnea	☐	☐	Low blood pressure	☐	☐	Cancer – Type:_____
☐	☐	Difficulty sleeping	☐	☐	High cholesterol/triglycerides	☐	☐	Kidney disease
☐	☐	Depression	☐	☐	Stroke	☐	☐	Dialysis
☐	☐	Nervousness/anxiety	☐	☐	Dizziness	☐	☐	Leakage or urine/stool
☐	☐	Psychiatric illness	☐	☐	Migraines/headache	☐	☐	Pain on urination
☐	☐	Arthritis	☐	☐	Epilepsy/seizures	☐	☐	Difficulty urinating
☐	☐	Osteoporosis			Date of last seizure:_____	☐	☐	Bladder/kidney infection
☐	☐	Mononucleosis	☐	☐	Parkinson's disease	☐	☐	Kidney stone
☐	☐	Organ transplant	☐	☐	Paralysis	☐	☐	Ostomy
☐	☐	HIV/AIDS	☐	☐	Hepatitis	☐	☐	Sexual problems
☐	☐	Sickle cell anemia/trait	☐	☐	Hormone replacement therapy	☐	☐	Amputation
☐	☐	Anemia	☐	☐	Loss of appetite	☐	☐	Prosthesis
☐	☐	Bleeding disorder	☐	☐	Recent weight gain/loss	☐	☐	Falls
☐	☐	Blood clot(s)	☐	☐	Special diet/dietary/fluid intake	☐	☐	Birth defects
☐	☐	Varicose veins			concerns?: _____	☐	☐	Recent jaundice
☐	☐	Heart Attack	☐	☐	Regular exercise? If yes, describe:	☐	☐	Sexually transmitted disease
☐	☐	Angina/chest pain			_____			Other:_____

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Patient Self History (cont.)

Preferred Pharmacy

☐ Local:_____ ☐ Mail Order:_____

Medications

Please include all prescriptions, over-the-counter medications, inhaler/nebulizer, insulin, ointments, creams, powders, patches, nose drop/spray, eye drops, suppositories and herbal supplements.

	Name of Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

List any additional medications on the back of this form.

Drug Allergies

☐ **I have no known drug allergies** Please include all prescriptions and over-the-counter medications.

	Drug	Reaction
1		
2		
3		
4		
5		

Other Allergies (food, environment, etc.):_____

Are you allergic to rubber/latex: ☐ Yes ☐ No

Have you ever had any surgeries? ☐ No ☐ Yes. List/date:_____

_____ _____

_____ _____

_____ _____

_____ _____

Family History

☐ **I am adopted**

(Check all boxes that apply)

	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐
Lung disease/asthma	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Cancer (include type)	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

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Patient Self History (cont.)

Female Only

When was your last menstrual period?_____
Age when periods began:_____
Are your periods regular? ☐Yes ☐No
How many days do you flow? _____
Flow: ☐Mild ☐Moderate ☐Severe
Do you have bleeding between periods? ☐Yes ☐No
Do you have pain with your periods? ☐Yes ☐No
If yes, what do you use for pain relief?_____
Regular self breast exams? ☐Yes ☐No

Pregnancy History

Are you currently breastfeeding? ☐Yes ☐No
Number of pregnancies:_____
Number of live births:_____
☐Preclampsia ☐Cesarean section
☐Birth defects ☐High blood pressure
Number of stillbirths: _____
Number of miscarriages:_____
Number of abortions:_____

Male Only

Do you have any difficulty (Check all that apply):
☐Urinating ☐Weak stream ☐Getting up at night to urinate ☐Trouble getting or maintaining an erection
Regular testicular self exams: ☐Yes ☐No

Male & Female

Age you first had sex:_____
Total # of sexual partners to date:_____
Are you currently sexually active? ☐Yes ☐No
Do you have sex with: ☐Men ☐Women ☐Both

Have you been with more than one partner in the last six months? ☐Yes ☐No
How long have you been with your current sexual partner?
_____

If you have cultural or religious beliefs that would influence your medical care, please indicate below and discuss with the provider:

☐ I have completed an Advance Directive (Please bring a copy to the office)
☐ I would like to complete an Advance Directive Form or would like to learn more about Advance Directives
☐ Decline Advance Directive
How would you prefer to learn?: ☐Written material/reading ☐Video/TV ☐Discussion/verbal

Additional Medical History (Any additional information about your medical history):

Time:_____ **Date:**_____ **Patient Signature:**_____

Time:_____ **Date:**_____ **Provider Signature:**_____

Reviewed and Updated: _____ _____ _____

_____ _____ _____

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Last Name:_____ Patient M.I.:_____ Patient First Name:_____

DOB:_____ Medical Record Number:_____

Physician Name:_____ Date Consent Discussed:_____

Introduction:

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her PCP's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial after reading this page:_____

INFORMED CONSENT FOR TELEMEDICINE SERVICES CONT.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My PCP has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my PCP of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (name of dermatologist) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient-(or person authorized to sign for patient): _____

Date: _____

If authorized signer, relationship to patient:_____

Witness: _____

Date: _____

I have been offered a copy of this consent form (patient's initials):_____