Trinity Health

IHA Medical Group

Welcome!

We are pleased that you have chosen our practice for your healthcare needs. Caring for you is our privilege. Enclosed are several informational items that will acquaint you with the practice and provide useful information about your care with us. We encourage you to take a few minutes to look through the information provided. If you have any questions or concerns, please feel free to call a member of our staff at the main practice phone number. Please refer to the enclosed practice brochure for location information. Additionally, our website has been designed to assist patients with frequently asked questions and directions to our locations. Visit us at IHAcares.com.

In preparation for your appointment, please:

- complete the enclosed new patient forms located on the right-hand side of your packet.
- be sure to bring the listed items to your appointment, outlined in this packet.
- plan to arrive to your appointment 15 minutes early, in order to complete the patient registration process.

Please note that minor children (under 18 years of age) must be accompanied by a parent, or legal guardian, for most services, unless we have written consent on file. If you wish to have a minor consent on file, please complete the enclosed form and bring it with you to your appointment.

We accept most common insurance plans. We are happy to submit the claim to participating insurance companies. If we do not participate with your carrier, or your services are not covered, you will be responsible for your balance at the time of service. Please understand your coverage prior to your visit. If you have any billing questions, our reception staff will be happy to assist you.

Again, thank you for choosing IHA Medical group. We look forward to providing you with superior care and service. Please contact our office if you have any further questions prior to your appointment.

Sincerely,

IHA Medical Group Providers & Staff

Trinity Health

IHA Medical Group

Missed Appointment Policy

Dear Patient,

We strive to create as many appointments as possible for our physicians and nurse practitioners so that we can provide all the services needed by our patients. We need the help of our patients to make our system work. We know and understand how busy everyone's lives are and we know plans change. We would like the courtesy of a call if an appointment cannot be kept.

It is our policy that any scheduled appointment be canceled with **at least 24 hours** notice to the appointment time except in the case of an unforeseen emergency.

If an appointment is canceled, we will do our best to give our patient the next available appointment time for the type of visit required.

If you fail to keep an appointment, our office will send a letter notifying you of the missed appointment and the missed appointment will be noted in your chart. There will be no charge for one missed appointment. However, in the event of a second and third missed appointment or late notice of cancel, there will be a charge of $39. Three missed appointments may cause dismissal from our practice.

Please understand this policy will not affect those patients who keep their appointments. In an office with many missed appointments we are trying to accommodate those patients that need to be seen in our office. We look forward to your anticipated understanding and cooperation.

Sincerely,

IHA Medical Group Providers & Staff

Patient Financial Obligations

IHA is dedicated to providing the best possible care and service to our patients in a cost-effective manner. We regard the patient's prompt handling of their financial responsibility as essential to ensure that we can provide quality services. In order to accomplish this, we depend upon prompt payment for the services we provide. To reduce any misunderstanding or confusion, we have adopted the following policy.

Payment options if you have insurance:
IHA has made prior arrangements with most insurance companies and health plans to accept assignment of benefits. We will file a claim with all insurance companies we participate with. Please be advised that unreported changes in medical insurance could result in billing delays, rejections and personal responsibility for the services provided.

Financial Responsibilities:

A. **You will need to pay your deductible, co-pay and any determined out-of-pocket portions at the time of service**. Unpaid co-pays will be reported to your carrier since this is a requirement of your insurance plan and may affect your insurance coverage.

B. **Bring your current insurance information to each visit.** Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. **It is your responsibility to understand your insurance benefits to include deductible amounts**.

C. If your health plan considers the service to be a "non-covered" benefit, you will be responsible for the charges at the time of service. If we are unable to verify coverage, you will be asked to sign a waiver (written acknowledgement) that these charges may not be covered, and you will be responsible for prompt payment of all uncovered services.

D. You should understand that your failure to meet your financial obligations to IHA may include (but is not limited to) additional actions such as written correspondence, collection activities, reporting to outside credit bureaus and termination of your patient relationship with IHA.

Payment options if you have no insurance:
Payment is expected on the day that treatment is rendered unless prior arrangements have been made. You can pay by cash, check, MasterCard, VISA or Discover. Alternative payment plans may be available for those patients who qualify (when made prior to your appointment).You may inquire about this with an IHA financial representative at your office.

Patient Appointments: We make every effort to see our patients promptly, likewise we ask that you arrive 15 minutes before your scheduled time to register and complete paperwork so that your arrival time does not impact our ability to keep our scheduled times with you or other patients. Note that patients who are sick or have a serious problem often need to be seen on the same day. The office reserves the right to charge for "missed appointments", and you should be familiar with our missed appointment policy. We ask that patients call the office promptly if you expect to be a late arrival, are unable to keep an appointment, or need to reschedule.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for payment. Minors must be accompanied by a parent or legal guardian to be treated. Any exception requires the parent or legal guardian to provide IHA, prior to treatment, a signed "Authorization" to provide medical treatment.

Monthly Statement: If you have a balance on your account, you will be billed promptly. It will show separately the patient balance due for each visit. The total amount due from you will be summarized at the bottom of the statement. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt.

Billing Fees: Any balances not paid upon receipt of your statement will be assessed a monthly **late charge** at the rate of 1.5% of the outstanding adjusted balance of your account. The adjusted balance is determined by taking the patient balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. Collection Fees of $33 per transaction will be assessed for returned or NSF checks. Further collection activity and late charges can be avoided by the timely payment of your account.

PLEASE READ THE ABOVE PATIENT OBLIGATIONS AND AGREE TO FOLLOW THIS POLICY. FURTHER, UNDERSTAND THAT FINANCIAL ASSISTANCE IS AVAILABLE TO YOU UPON REQUEST. PLEASE CONTACT AN IHA FINANCIAL ADVOCATE TO ASSIST YOU AT: (734) 997-7700.

Notice of Privacy Practices

Effective Date: April 14, 2003
Revised: May 23, 2022

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

Trinity Health Michigan (THMI) is required by the Health Insurance Portability and Accountability Act of 1996, and the Health Information Technology for Economic and Clinical Health Act (found in Title XIII of the American Recovery and Reinvestment Act of 2009) (collectively referred to as "HIPAA"), as amended from time to time, to maintain the privacy of individually identifiable patient health information (this information is "protected health information" and is referred to herein as "PHI"). We are also required to provide patients with a Notice of Privacy Practices regarding PHI. We will only use or disclose your PHI as permitted or required by applicable state law. This Notice applies to your PHI in our possession including the medical records generated by us.

THMI understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we will use and disclose your PHI.

This Notice applies to the delivery of health care by THMI and its medical staff in the main hospitals, outpatient departments, clinics, home care and hospice programs, system-owned physician practices, and pharmacies. This Notice also applies to the utilization review and quality assessment activities of THMI as a member of Trinity Health, a Catholic health care system with facilities located in multiple states throughout the United States.

I. Permitted Use or Disclosure

A. Treatment: THMI will use and disclose your PHI to provide, coordinate, or manage your health care and related services to carry out treatment functions. The following are examples of how THMI will use and/or disclose your PHI:

i. To your attending physician, consulting physician(s), and other health care providers who have a legitimate need for such information in your care and continued treatment.
ii. To coordinate your treatment (e.g., appointment scheduling) with us and other health care providers such as name, address, employment, insurance carrier, etc.
iii. To contact you as a reminder that you have an appointment for treatment or medical care at our facilities.
iv. To provide you with information about treatment alternatives or other health-related benefits or services.
v. If you are an inmate of a correctional institution or under the custody of a law enforcement officer, THMI will disclose your PHI to the correctional institution or law enforcement official.

B. Payment: THMI will use and disclose PHI about you for payment purposes. The following are examples of how THMI will use and/or disclose your PHI:

i. To an insurance company, third party payer, third party administrator, health plan or other health care provider (or their duly authorized representatives) for payment purposes such as determining coverage, eligibility, pre-approval / authorization for treatment, billing, claims management, reimbursement audits, etc.
ii. To collection agencies and other subcontractors engaged in obtaining payment for care.

C. Health Care Operations: THMI will use and disclose your PHI for health care operations purposes. The following are examples of how THMI will use and/or disclose your PHI:

i. For case management, quality assurance, utilization, accounting, auditing, population-based activities relating to improving health or reducing health care costs, education, accreditation, licensing, and credentialing activities of THMI.
ii. To consultants, accountants, auditors, attorneys, transcription companies, information technology providers, etc.

D. Other Uses and Disclosures: As part of treatment, payment, and health care operations, THMI may also use your PHI for the following purposes:

i. Fundraising Activities: THMI will use and may also disclose some of your PHI to a related foundation for certain fundraising activities. For example, THMI may disclose your demographic information, your treatment dates of service, treating physician information, department of service and outcomes information to the foundation who may ask you for a monetary donation. Any fundraising communication sent to you will let you know how you can exercise your right to opt-out of receiving similar communications in the future.
ii. Medical Research: THMI will use and disclose your PHI without your authorization to medical researchers who request it for approved medical research projects. Researchers are required to safeguard all PHI they receive.
iii. Information and Health Promotion Activities: THMI will use and disclose some of your PHI for certain health promotion activities. For example, your name and address will be used to send you general newsletter or specific information based on your own health concerns.

E. More Stringent State and Federal Laws: The State law of Michigan is more stringent than HIPAA in several areas. Certain federal laws also are more stringent than HIPAA. THMI will continue to abide by these more stringent state and federal laws.

Scan here to read a digital copy.

i. **More Stringent Federal Laws:** The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.
ii. **More Stringent State Laws:** State law is more stringent when the individual is entitled to greater access to records than under HIPAA. State law also is more restrictive when the records are more protected from disclosure by state law than under HIPAA. In cases where THMI provides treatment to a patient who resides in a neighboring state, THMI will abide by the more stringent applicable state law.

F. Health Information Exchange: THMI shares your health records electronically or otherwise with state-designated Health Information Exchange] ("HIE") that exchange health records with other HIEs. THMI also uses data exchange technology (such as direct messaging services, HIPS, and provider portals) with its Electronic Health Record ("EHR") to share your health records for continuity of care and treatment. HIEs and data exchange technology also enable the sharing of your health records to improve the quality of health care services provided to you (e.g., avoiding unnecessary duplicate testing). The shared health records will include, if applicable, sensitive diagnoses such as HIV/AIDS, sexually transmitted diseases, genetic information, and mental health substance abuse, etc. HIEs and data exchange technology function as our business associate and, in acting on our behalf, they will transmit, maintain, and store your PHI for treatment, payment and health care operation purposes. HIEs and data exchange technologies are required to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of your medical information. State law may provide you rights to restrict, opt-in, or opt-out of HIE(s). For more information, please contact THMI's Privacy Officer at 734.712.3577.

II. Permitted Use or Disclosure with an Opportunity for You to Agree or Object

A. Family/Friends: THMI will disclose PHI about you to a friend or family member who is involved in or paying for your medical care. You have a right to request that your PHI not be shared with some or all of your family or friends. In addition, THMI will disclose PHI about you to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status, and location.

B. THMI Directory: THMI may include certain information about you in a directory while you are a hospital patient at THMI. This information will include your name, location in THMI, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation. The directory information, except your religious affiliation, will be disclosed to people who ask for you by name. You have the right to request that your name not be included in THMI's directory. If you request to opt-out of the directory, we cannot inform visitors of your presence, location, or general condition.

C. Spiritual Care: Directory information, including your religious affiliation, will be given to a member of the clergy, even if they do not ask for you by name. Spiritual care providers are members of the health care team at Trinity Health and may be consulted upon regarding your care. You have the right to refuse services offered by the Trinity Health Spiritual Care team. You also have the right to request that your name not be given to any member of the community (non-Trinity Health affiliated) clergy.

D. Media Reports: THMI will release facility directory information to the media (excluding religious affiliation) if the media requests information about you using your name and after we have given you an opportunity to agree or object.

III. Use or Disclosure Requiring Your Authorization

A. Marketing: Subject to certain limited exceptions, your written authorization is required in cases where THMI receives any direct or indirect financial remuneration in exchange for making the communication to you which encourages you to purchase a product or service or for a disclosure to a third party who wants to market their products or services to you.

B. Research: THMI will obtain your written authorization to use or disclose your PHI for research purposes when required by HIPAA.

C. Psychotherapy Notes: Most uses and disclosures of psychotherapy notes require your written authorization.

D. Sale of PHI: Subject to certain limited exceptions, disclosures that constitute a sale of PHI require your written authorization.

E. Other Uses and Disclosures: Any other uses or disclosures of PHI that are not described in this Notice of Privacy Practices require your written authorization. Written authorizations will let you know why we are using your PHI. You have the right to revoke an authorization at any time.

IV. Use or Disclosure Permitted or Required by Public Policy or Law without your Authorization

A. Law Enforcement Purposes: THMI will disclose your PHI for law enforcement purposes as required by law, such as identifying a criminal suspect or a missing person or providing information about a crime victim or criminal conduct.

B. Required by Law: THMI will disclose PHI about you when required by federal, state, or local law. Examples include disclosures in response to a court order / subpoena, mandatory state reporting (e.g., gunshot wounds, victims of child abuse or neglect), or information necessary to comply with other laws such as workers' compensation or similar laws. THMI will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies.

C. Public Health Oversight or Safety: THMI will use and disclose PHI to avert a serious threat to the health and safety of a person or the public. Examples include disclosures of PHI to state investigators regarding quality of care or to public health agencies regarding immunizations, communicable diseases, etc. THMI will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA regulated products or activities, including collecting and reporting adverse events, tracking, and facilitating in product recalls, etc.

D. Coroners, Medical Examiners, Funeral Directors: THMI will disclose your PHI to a coroner or medical examiner. For example, this will be necessary to identify a deceased person or to determine a cause of death. THMI may also disclose your medical information to funeral directors as necessary to carry out their duties.

E. Organ Procurement: THMI will disclose PHI to an organ procurement organization or entity for organ, eye, or tissue donation purposes.

F. Specialized Government Functions: THMI will disclose your PHI regarding government functions such as military, national security and intelligence activities. THMI will use or disclose PHI to the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

G. Immunizations: THMI will disclose proof of immunization to a school where the state or other similar law requires it prior to admitting a student.

V. Your Health Information Rights

You have the following individual rights concerning your PHI:

A. Right to Inspect and Copy: Subject to certain limited exceptions, you have the right to access your PHI and to inspect and copy your PHI as long as we maintain the data.

If THMI denies your request for access to your PHI, THMI will notify you in writing with the reason for the denial. For example, you do not have the right to psychotherapy notes or to inspect the information which is subject to law prohibiting access. You may have the right to have this decision reviewed.

You also have the right to request your PHI in electronic format in cases where THMI utilizes electronic health records. You may also access information via patient portal if made available by THMI.

You will be charged a reasonable copying fee in accordance with applicable federal or state law.

B. Right to Amend: You have the right to amend your PHI for as long as THMI maintains the data. You must make your request for amendment of your PHI in writing to THMI, including your reason to support the requested amendment.

However, THMI will deny your request for amendment if:

i. THMI did not create the information;
ii. The information is not part of the designated record set;
iii. The information would not be available for your inspection (due to its condition or nature); or
iv. The information is accurate and complete.

If THMI denies your request for changes in your PHI, THMI will notify you in writing with the reason for the denial. THMI will also inform you of your right to submit a written statement disagreeing with the denial. You may ask that THMI include your request for amendment and the denial any time that THMI subsequently discloses the information that you wanted changed. THMI may prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal.

C. Right to an Accounting: You have a right to receive an accounting of the disclosures of your PHI that THMI has made, except for the following disclosures:

i. To carry out treatment, payment, or health care operations;
ii. To you;
iii. To persons involved in your care;
iv. For national security or intelligence purposes; or
v. To correctional institutions or law enforcement officials.

You must make your request for an accounting of disclosures of your PHI in writing to THMI.

You must include the time period of the accounting, which may not be longer than 6 years. In any given 12-month period, THMI will provide you with an accounting of the disclosures of your PHI at no charge. Any additional requests for an accounting within that time period will be subject to a reasonable fee for preparing the accounting.

D. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI to carry out treatment, payment, or health care operations functions or to prohibit such disclosure. However, THMI will consider your request but is not required to agree to the requested restrictions.

E. Right to Request Restrictions to a Health Plan: You have the right to request a restriction on disclosure of your PHI to a health plan (for purposes of payment or health care operations) in cases where you paid out of pocket, in full, for the items received or services rendered.

F. Right to Confidential Communications: You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that THMI only contact you at work or by mail.

G. Right to Receive a Copy of this Notice: You have the right to receive a paper copy of this Notice of Privacy Practices, upon request.

VI. Breach of Unsecured PHI

If a breach of unsecured PHI affecting you occurs, THMI is required to notify you of the breach.

VII. Sharing and Joint Use of Your Health Information

In the course of providing care to you and in furtherance of THMI's mission to improve the health of the community, THMI will share your PHI with other organizations as described below who have agreed to abide by the terms described below:

A. Medical Staff. The medical staff and THMI participate together in an organized health care arrangement to deliver health care to you at THMI. Both THMI and its medical staff have agreed to abide by the terms of this Notice with respect to PHI created or received as part of delivery of health care to you in THMI. Physicians and allied health care professionals are members of THMI's medical staff will have access to and use your PHI for treatment, payment and health care operations purposes related to your care with THMI. The THMI will disclose your PHI to the medical staff for treatment, payment, and health care operations.

B. Membership in Trinity Health. THMI and other members of Trinity Health participate together in an organized health care arrangement for utilization review and quality assessment activities. As a part of Trinity Health, a national Catholic health care system, THMI and other hospitals, nursing homes, and health care providers in Trinity Health share your PHI for utilization review and quality assessment activities of Trinity Health, the parent company, and its members. Members of Trinity Health also use your PHI for your treatment, payment to THMI and/or for the health care operations permitted by HIPAA with respect to our mutual patients. All members of Trinity Health have agreed to abide by the terms of this Notice with respect to PHI created or received as part of utilization review and quality assessment activities. Members of Trinity Health will abide by the terms of their own Notice of Privacy Practices in using your PHI for treatment, payment, or health care operations.

Please go to Trinity Health's websites for a listing of member organizations at http://www.trinity-health.org/. Or, alternatively, you can call THMI's Privacy Official to request the same.

C. Business Associates. THMI will share your PHI with business associates and their Subcontractors contracted to perform business functions on THMI's behalf, including Trinity Health which performs certain business functions for THMI.

D. Your Health Care Providers and Care Coordinators. You receive care from THMI delivered in an integrated care setting, where patients are seen by several different providers and in several care settings as part of continuity of care and coordinated care delivery. THMI shares your PHI with other health care providers and care coordinators who work together to provide treatment, obtain payment, and conduct health care operations. Your PHI is shared electronically in multiple ways with providers involved in the delivery of care and care coordination. Your PHI may be shared via a direct connection to the electronic health record system of other providers. Your PHI may be shared in a health information exchange or via technology that enables downstream providers and care coordinators to obtain your information. Your PHI may be shared via secure transmission to other providers' inboxes.

VIII. Changes to this Notice.

THMI will abide by the terms of the Notice currently in effect. THMI reserves the right to make material changes to the terms of its Notice and to make the new Notice provisions effective for all PHI that it maintains. The new notice will be available upon request, in our office, and on our web site. You can also ask THMI for a current copy of the Notice at any time.

IX. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with THMI's Privacy Official. All complaints must be submitted in writing directly to THMI's Privacy Official You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. **THMI assures you that you will not be retaliated against for filing any complaint.**

X. Privacy Official – Questions / Concerns / Additional Information.

If you have any questions, concerns, or want further information regarding the issues covered by this Notice of Privacy Practice or seek additional information regarding THMI's privacy policies and procedures, please contact THMI's Privacy Officer: 5301 McAuley Dr, Ypsilanti, MI 48197,734.712.3577.

Trinity Health

Patient Centered Medical Home

A Patient Centered Medical Home is health care focused on you, the patient. It is a partnership between you and your doctor. Your doctor leads a team of health care professionals committed to improving your overall health and to helping you reach your health goals. Your health team will be led by your primary care physician and may also include nurses, specialty physicians, a nutritionist, care managers and others depending on your needs. Instead of being treated for a problem here and there without making a connection between symptoms, the Patient Centered Medical Home focuses on connecting the dots and coordinating care. Do not hesitate to come to us with any questions you may have.

Join the MyChart Patient Portal

The MyChart Patient Portal offers patients electronic access to their health care information and a way to communicate with their physician's office that is convenient, safe and secure. The MyChart Patient Portal offers secure access to many important services.

As we move into the future, you may notice that:

- We ask you what your goals are, or what you want to do to improve your health or the health of your family member.
- We ask you to help us plan your or your child's care and let us know if you think you or they can follow the plan.
- We give you a written copy of the care plan.
- The care team members are actively involved in planning the care you receive.
- We remind you when tests are due so that you or your child receive the best quality care.
- We ask that blood tests are done before the visit so that the doctor has the results at your or your child's visit.
- We offer patients a chance to join in a special type of visit called a "group visit."

A partnership means that we trust you to:

- Communicate openly about any symptoms or changes in your or your family member's health and well-being.

- Learn about wellness and disease prevention and make healthy decisions about you and your family's daily habits and lifestyle.
- Follow the care plan that is agreed upon – or let us know why you are not able to so that we can try to help or change the plan.
- Tell us when you or your family member see other doctors, have a change in medication(s) or have received any other tests or treatments. Please ask them to send us a report so we are well-informed.
- Learn and become familiar with the insurance that covers you and your family.
- Respect us as individuals and partners in your care.
- Give us feedback so that we can improve our services.
- Come prepared to pay your office visit fee when you are seen in the office.

Continued →

Trinity Health

Trinity Health IHA Medical Group

Prescription Renewals

It is important that you ask to have prescription(s) renewed at the time of your visit. Many medications may require an office visit before they can be renewed. Please keep this in mind so that you do not run out of medication(s) before the next office visit.

If you think you or your family member may run out of medication(s) before the next office visit, you may request a renewal through the MyChart Patient Portal on IHAcares.com or call the office at least 24 hours in advance. Please have the name and dosage of the medication(s) and your pharmacy information ready when you call.

Appointments

We know that your time is valuable and we do our best to see our patients at their scheduled time. Patients are encouraged to arrive at least 15 minutes early and sign in at the front desk. This extra time allows our staff to update records prior to you seeing the provider. If you are unable to keep your or your family member's scheduled appointment, please notify us so that we may let another patient have that appointment time. Frequently missed appointments may result in a missed appointment fee.

We are Enhancing the Way We Deliver Health Care

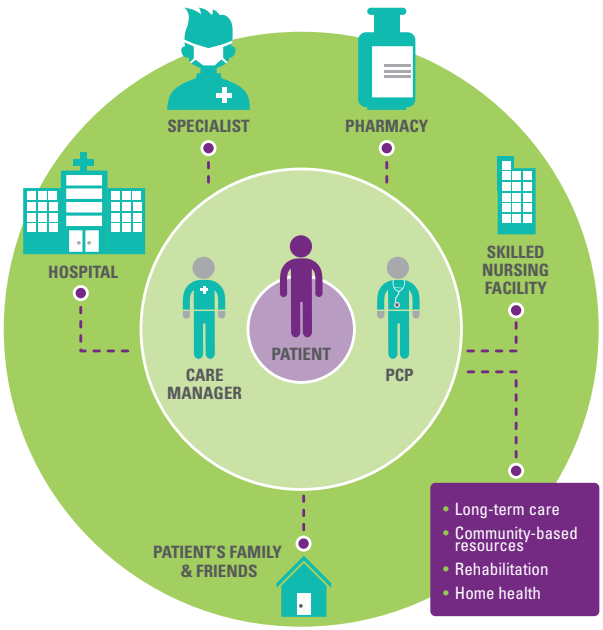
Patient Centered Medical Home (PCMH)

PCMH patients and their family (when appropriate) establish a partnership with their practitioners to ensure they have the support and education needed to make decisions and participate in their own health care.

Patient Centered Medical Home - Neighborhood (PCMH-N)

PCMH-N begins with you, the patient, at the center. Your "neighborhood" consists of your primary care physician/nurses, along with specialty physicians, social workers, or other medical professionals depending on your needs. The PCMH-N team is committed to helping you reach your health care goals and improve your overall health through timely, appropriate and coordinated care.

The Medical Neighborhood



Trinity Health IHA Urgent Care

Our urgent care locations not only offer extended hours seven days a week including holidays, but also now offer patients the ability to **save their spot**. This allows patients to seek care at a time and location that is convenient for them. That also includes urgent care video visits in as soon as 10 minutes.

To learn more, visit: **IHAcares.com/saveyourspot**

SCAN HERE TO SAVE YOUR SPOT!

Please visit us online for the most up-to-date hours at: **IHAcares.com/urgentcare**

Trinity Health

Trinity Health IHA Medical Group

MyChart

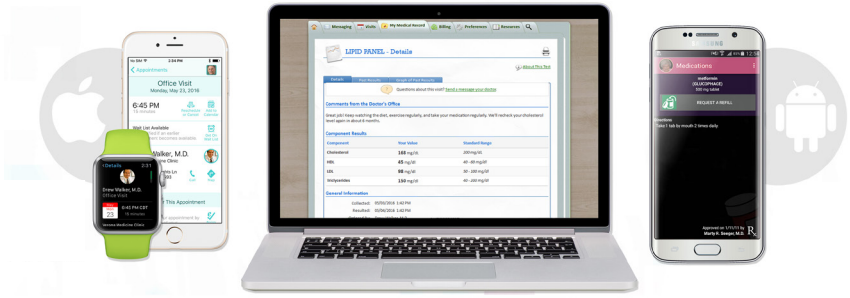
MyChart Waiting? Sign Up

Sign up for MyChart to get the results from any tests you have today sooner! You'll also get notes from your visit right to your phone.

Ask the medical assistant to send you a registration link or type **mychart.trinity-health.org** into you phone's browser and click **Sign up now**.

Sign up today at mychart.trinity-health.org

iOS



Android

MyChart is available through any web browser at mychart.trinity-health.org, or download the Trinity Health MyChart mobile app on your smart phone.

With MyChart you can:

- Manage Your Appointments
- Online visits
- Access your test results
- Communicate with your doctor
- Pay bills online
- Request prescription refills

Trinity Health
IHA Medical Group

Trinity Health
IHA Medical Group

Adult History New Patient Form

PLEASE BRING ALL MEDICATION(S) TO YOUR APPOINTMENT.

Please complete this form and bring it with you to your visit.

Date: _____

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Birth Sex: ☐ Male ☐ Female ☐ Undifferentiated **Current Gender Identity:** ☐ Choose not to disclose ☐ Female ☐ Female-to-Male/Transgender Male ☐ Genderqueer ☐ Male ☐ Male-to-Female/Transgender Female

Preferred Pronoun: ☐ Decline to answer ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other_____

☐ Single ☐ Married ☐ Widow(er) ☐ Partner ☐ Divorced **Who do you live with?** ☐ Alone ☐ Partner ☐ Family ☐ Other

Email: _____ Would you like to enroll in the Patient Portal? ☐ Yes ☐ No

Occupation: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Insurance: _____ Policy Number: _____

Having race, ethnicity and language information for all of our patients helps us know them better.

Race: ☐ Alaskan Native or American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Other _____ ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

Are there any other languages spoken in the home? If yes, please list:

_____

Preferred Pharmacy: _____

Address: _____

Phone: _____ Fax: _____

☐ **Routine Check Up — No Symptoms**

Reason for Visit: *(please list all current symptoms)*

1. _____
2. _____
3. _____

Chronic Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you take your medications as directed? ☐ Yes ☐ No

***Please bring all medications to your visit in a bag.**

Name of Medication	Dosage	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		

Supplements / Herbs / Over the counter medication:

1. _____
2. _____

Allergies:

Source	Reaction	Source	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever had any of the following?

(If yes, enter date to those that apply)

TEST	Date
Eye Exam	
Dental Exam	
Cholesterol	
PPD (TB test)	
HIV test	
Hepatitis C	
Stool blood test	
Colonoscopy	
Bone density	
Chest X-Ray	
Heart Stress Test	
Blood transfusion	
MRI	
Sleep Study	
Other	

Surgical History	Date
Angioplasty	
Appendectomy	
Arthroscopy of knee	
Back surgery	
CABG (Heart bypass)	
Carpal tunnel release	
Cataract extraction	
Colon resection	
Colostomy	
Defibrillator	
Fracture	
Location:	
Gallbladder out	
Gastric bypass	
Gastric Band	
Gastric Sleeve	

Surgical History	Date
Heart Valve	
Hernia repair	
Hip/Knee replacement	
Hysterectomy	

Why did you have a hysterectomy? _____

Was your cervix removed? ☐ Yes ☐ No

Were your ovaries removed? ☐ Yes ☐ No

Did you have a vaginal hysterectomy? ☐ Yes ☐ No

LASIK	
Mastectomy	
Small bowel resection	
Thyroidectomy	
Tonsillectomy	
Pacemaker	
Prostate surgery	
Other	

Other recent physician or hospital visits:

1. _____ **2.** _____ **3.** _____

Social History *(Check all that apply)*

Alcohol Use ☐ Yes ☐ No ☐ Former

Years Drinking _____

Drinks per week _____

Type _____

Quit date _____

Last drink _____

Caffeine ☐ Yes ☐ No Amount/week

Coffee _____

Pop/Soda _____

Energy drinks _____

Other: _____

Exercise ☐ Yes ☐ No

Frequency (Hours/week): _____

Types:

Tobacco ☐ Yes ☐ No ☐ Former

☐ Cigarettes

Packs per day _____

☐ Cigars

☐ Chewing Tobacco

☐ Would like to quit

Years of use _____

Year quit _____

Sexual History

Are you currently sexually active?

☐ Yes ☐ No

Any history of sexually transmitted diseases? ☐ Yes ☐ No

If yes, when?

Recreational drug use

☐ Yes ☐ No ☐ Former

Have you ever used IV drugs?

☐ Yes ☐ No

Personal safety

Do you wear your seatbelt?

☐ Yes ☐ No

Do you have difficulty dressing yourself?

☐ Yes ☐ No

Do you have difficulty carrying 10 pounds?

☐ Yes ☐ No

Do you have difficulty shopping?

☐ Yes ☐ No

Other

Have you experienced a fall in the last year? ☐ Yes ☐ No If yes, how many times have you fallen this year?_____

Were you injured in the fall(s)? ☐ Yes ☐ No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Feeling down, depressed or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Do you work? ☐ Yes ☐ No ☐ Retired

Do you have a Living Will/Durable Power of Attorney? ☐ Yes ☐ No

How many children do you have? _____

Personal and Family History ☐ Unknown/Adopted

(Check all that apply)

Circle any items that were known cause of death for relative

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
ADD/ADHD	☐ Yes	☐ Yes	
Alcoholism	☐ Yes	☐ Yes	
Allergies	☐ Yes	☐ Yes	
Alzheimer's Disease/Dementia	☐ Yes	☐ Yes	
Anemia	☐ Yes	☐ Yes	
Angina	☐ Yes	☐ Yes	
Anxiety	☐ Yes	☐ Yes	
Arthritis	☐ Yes	☐ Yes	
Asthma	☐ Yes	☐ Yes	
Atrial fibrillation	☐ Yes	☐ Yes	
BPH (enlarged prostate)	☐ Yes	☐ Yes	
Blood clots	☐ Yes	☐ Yes	
Blood disease (vists to hematology)	☐ Yes	☐ Yes	
Cancer(s):			
Breast	☐ Yes	☐ Yes	
Colon	☐ Yes	☐ Yes	
Lung	☐ Yes	☐ Yes	
Prostate	☐ Yes	☐ Yes	
Other:	☐ Yes	☐ Yes	
CVA (Stroke or TIA)	☐ Yes	☐ Yes	
Colon problems	☐ Yes	☐ Yes	
COPD (emphysema)	☐ Yes	☐ Yes	
Coronary artery disease	☐ Yes	☐ Yes	
Depression	☐ Yes	☐ Yes	
Developmental Delay	☐ Yes	☐ Yes	
Diabetes	☐ Yes	☐ Yes	
Eczema	☐ Yes	☐ Yes	
Gall Stones	☐ Yes	☐ Yes	
Gallbladder disease	☐ Yes	☐ Yes	
GERD	☐ Yes	☐ Yes	
Glaucoma/Cataracts	☐ Yes	☐ Yes	
Hearing deficiency	☐ Yes	☐ Yes	
Heart disease/problems	☐ Yes	☐ Yes	
before age 40 (male)	☐ Yes	☐ Yes	
before age 50 (female)	☐ Yes	☐ Yes	
Hemorrhoids	☐ Yes	☐ Yes	
Hernia	☐ Yes	☐ Yes	
Hepatitis C	☐ Yes	☐ Yes	
Hyperlipidemia (high cholesterol)	☐ Yes	☐ Yes	
Hypertension (high blood pressure)	☐ Yes	☐ Yes	
Injuries:			
Concussion or head injury	☐ Yes	☐ Yes	
Car/motorcycle accident injury	☐ Yes	☐ Yes	
Ever been knocked unconscious	☐ Yes	☐ Yes	
Broken bones?	☐ Yes	☐ Yes	
Which ones?			
Any other injuries:	☐ Yes	☐ Yes	

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
Irritable bowel disease	☐ Yes	☐ Yes	
Kidney disease	☐ Yes	☐ Yes	
Kidney stones	☐ Yes	☐ Yes	
Learning disability	☐ Yes	☐ Yes	
Liver disease	☐ Yes	☐ Yes	
Lupus	☐ Yes	☐ Yes	
Mental illness	☐ Yes	☐ Yes	
Migraines/headaches	☐ Yes	☐ Yes	
Obesity	☐ Yes	☐ Yes	
Osteoarthritis	☐ Yes	☐ Yes	
Osteoporosis	☐ Yes	☐ Yes	
Peptic ulcer disease	☐ Yes	☐ Yes	
Peripheral vascular disease	☐ Yes	☐ Yes	
Psoriasis	☐ Yes	☐ Yes	
Rheumatoid Arthritis	☐ Yes	☐ Yes	
Seizure disorder/Epilepsy	☐ Yes	☐ Yes	
Sleep Apnea	☐ Yes	☐ Yes	
Thyroid disease	☐ Yes	☐ Yes	
OTHER (please list)			
_____	☐ Yes	☐ Yes	
_____	☐ Yes	☐ Yes	

Have you had the following illnesses or vaccines?

Check all that apply **Date**

- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ HPV (Gardasil) _____
- ☐ Influenza _____
- ☐ Last tetanus vaccination _____
- ☐ Pneumonia (Pneumovax) _____
- ☐ Pneumonia (Prevnar) _____
- ☐ Shingles shot (Zostavax) _____

FOR WOMEN ONLY

How many: Pregnancies _____ Live births _____

Menstrual History:

Age when menstrual period began _____

Do you use any form of birth control? ☐ Yes ☐ No

If yes, what? _____

First day of last menstrual period _____

Screening Tests **Date**

Last pap smear: _____

Any abnormal pap smears and/or cervical procedures?

☐ Yes ☐ No If yes, indicate results and date.

Mammogram: _____

Any abnormal mammograms?

☐ Yes ☐ No If yes, indicate results and date.

Patient Signature: _____ Date Signed: _____ 05/23

Authorization for Sharing Information

Trinity Health
IHA Medical Group

1. THINGS YOU SHOULD KNOW (PRIVACY NOTICES):

a) You should know that **if using a policyholder/parent's health insurance** plan for services, IHA and the insurance company may share your information to the policyholder/parent for services you have performed. **In addition**, **they would receive an explanation of benefits**, **and may gain access to medical and billing information about your visit.**

b) Understand that this consent is for all locations and **will be in effect** until you revoke it in writing **or** for the **period specifically listed** here: _____. Further, you should understand that you may opt out of this type of release of information by providing written notice to your physician. Please note that completing a new Authorization to Share form automatically replaces the previous version on file.

c) If you give permission to share your health information with another person, that person could **re-disclose** your health information and your information is no longer protected by Federal privacy regulations. Your health care will not be affected if you do not sign this form. ***When we share information with others, they may be able to share it with others.***

This is where you (the patient) fill in YOUR information.

2. PATIENT:_____/_____

LAST NAME FIRST NAME MI MAIDEN OR OTHER NAME DATE OF BIRTH

ADDRESS: _____

CITY: _____ STATE:_____ ZIP: _____

CONTACT PHONE NUMBER(S):_____

EMAIL: _____

This is where you fill in the WHO you are allowing to get your information.

3. I CONSENT to share my health information with the following individual(s) involved in my care:

NAME:_____ DATE OF BIRTH:_____ (If Available)

ADDRESS: _____

PHONE:_____ RELATIONSHIP TO PATIENT: _____

NAME:_____ DATE OF BIRTH:_____ (If Available)

ADDRESS: _____

PHONE:_____ RELATIONSHIP TO PATIENT: _____

This is where YOU decide if you authorize IHA Medical Group to share your information as listed below.

4. I AGREE/DECLINE to share the following information: ***(THIS AUTH APPLIES TO ALL OFFICES)***

INITIAL BY YOUR CHOICE HERE

☐ **I AGREE** to share/release all relevant information, ***INCLUDING release of all the following.***

Special consent information: *HIV (Human Immunodeficiency Virus) related illness, testing OR Sexually Transmitted Diseases; AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex); Information about Alcohol and Drug Abuse Treatment; Information about Mental Health Services and Social Services. In addition, other private information such as pregnancy or contraceptive management information can be shared.*

EXCLUSION - Records excluded from disclosure are those that meet the requirements for CFR 42 Part 2 and require a separate consent for release.

☐ **I AGREE** to share/release all relevant information, ***EXCLUDING special consent areas above***.

☐ **I AGREE** to share/release ***ONLY*** this specific information: _____

☐ **I DECLINE** to share/release my health information.

_____ OR _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN DATE

PRESENTED ID: _____ **PROOF OF LEGAL GUARDIANSHIP (when applicable):** _____

PROCESSED BY THE FOLLOWING LOCATION: _____

STAFF INITIALS: _____ **DATE:** _____

Trinity Health
IHA Medical Group

AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Complete ALL Fields to ensure your request is processed

Note: You will not be contacted about the status of your requests, which can take up to thirty days to process. If you have questions, you can contact us at: 734-887-8966 or Medical_records@ihacares.com

AUTHORIZE AND REQUEST THE RELEASE OF INFORMATION BELOW FOR THE FOLLOWING PATIENT:

Patient Name: _____ Date of Birth: ___/___/____ Phone: _____

Address: _____City/State/Zip:_____

Email Address: _____

RELEASE RECORDS FROM:

☐ IHA/SMNG Provider Name: _____Office Name: _____

☐ All IHA/SJMG Provider/Offices _____ ☐ Other (Be specific) _____

RELEASE RECORDS TO:

☐ **Me**: I request Trinity Health to release my protected information to Myself at the address listed above.
☐ **Other**: I am the legally authorized representative of the patient listed above and request Trinity Health to release the protected health information to:

Name: _____Company/Organization_____

Address: _____City/State/Zip: _____

Email Address: _____Fax: _____

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at law, etc. *BILLING: Billing information will be mailed to the address stated above unless otherwise specified.

INFORMATION TO BE RELEASED: (Check all that apply)

Dates of service: ___/___/___ through ___/___/___

- ☐ Office Visits
- ☐ Outside Consult Notes
- ☐ Laboratory Reports
- ☐ Imaging/Films
- ☐ Radiology Reports
- ☐ Billing Record
- ☐ Entire Record
- ☐ Other: _____

PURPOSE OF RELEASE (check reason):

☐ Continuity of Care ☐ Transfer out ☐ Insurance ☐ Legal ☐ School ☐ Personal ☐ Workers Compensation

FORMAT (Charges may apply):

Format type: ☐ Encrypted link via Email ☐ Encrypted CD (delivered by Mail) ☐ Paper Copy (delivered by Mail)

Signature: _____ Print Name: _____Date:_____

Sensitive Information: I request the following Information be released, which may include alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS, or ARC; communicable disease or infections, including sexually transmitted disease, venereal disease, tuberculosis and hepatitis, genetic information, and demographic information, for the purposes and conditions designated on this form. ☐ 42CFR Part 2 decline to share information.

Right to Revoke (cancelling) authorization: I have the right to revoke (cancel) this limited authorization in writing at any time. Revocations must be made in writing and sent to Trinity Health Release of Information with the address on the top of this form. Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy or the policy itself.

Expiration: This authorization will expire in six months unless specified on the following date, event, or condition_____.

Re-disclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be re-disclosed and no longer protected by these regulations.

INTERNAL USE

PRESENTED ID: ☐ PROOF OF LEGAL GUARDIANSHIP: ☐ FEE COLLECTED: ☐ WRITTEN REQUEST TO REVOKE (ATTACH) ☐

VERIFIED BY: _____ DATE **RECEIVED:** _____

PROCESSED BY: _____ **DATE PROCESSED:** _____ **FORWARDING REQUEST TO MRO FOR PROCESSING ☐**

Physician Office Consent to Treatment

I. CONSENT FOR MEDICAL CARE, TESTING, AND TREATMENT:

A. I voluntarily consent to treatment which may include a complete medical history, physical examination, performance of diagnostic procedures, lab tests, x-rays, and other medical procedures as deemed necessary and appropriate by the physician, physician assistant, nurse practitioner and/or associates, including residents, students, nurses, technicians, and assistants (each a "Provider") participating in my care on behalf of [Trinity Health IHA Medical Group or Trinity Health Medical Group] ("Facility"). I understand that, absent an emergency or extraordinary circumstance, I have the right to discuss all procedures or treatments with any Provider participating in my care, and to refuse any proposed procedure or course of treatment.

B. I am aware that the practice of medicine and surgery is not an exact science, and that results and outcomes of treatment are different for each patient. I acknowledge that no guarantees or promises have been made to me regarding my health or the results or outcomes of any procedure, test, or treatment that I authorize my Provider to perform.

C. I authorize Facility to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

D. I understand that in the rare event that a Provider is exposed to my blood and/or body fluids, Facility may perform laboratory studies on my blood to detect the presence of any serious communicable diseases, such as hepatitis, HIV or AIDS. I understand Michigan law permits this testing without my consent and, should such testing occur, I will not be charged.

II. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND RELEASE OF HEALTH RECORD INFORMATION:

A. I acknowledge that I was offered and/or provided Facility's Notice of Privacy Practices, and that I may obtain an additional copy of the Notice at any time. This Notice describes how Facility uses and discloses protected personally identifiable information, including billing and medical information, in accordance with the protections of the law.

B. I understand that the Facility may release my personal, billing, and medical information to other institutions, facilities, providers, payers, insurance companies or review agencies for use in connection with my current or future care, health care operations, including quality improvement and care coordination, or as required for Facility or Providers to receive payment for care. I understand and agree that this may include the following: (i) alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2; (ii) information related to HIV infection or AIDS; (iii) psychological records, social services records, and confidential communications made to a psychologist, social worker, or other provider.

C. I understand and acknowledge that my information can be shared by Facility with other past, future, and current providers, caregivers, and facilities to coordinate my health care, for payment and for administrative purposes, including quality and care management, or as otherwise permitted or required by law. This information may include dates and services provided, location where treatment was received, treatment information, medications, diagnoses, names of physicians and other health care providers, including mental health professionals, and information related to diagnosis, care, or treatment of my mental or emotional condition.

D. I acknowledge that my health record information may be released to my employer if this is a work-related exam or an injury for which a workers compensation claim has been filed.

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III. AUTHORIZATION FOR PAYMENT/ FINANCIAL RESPONSIBILITY

A. I assign and authorize payment directly to Facility for all services rendered. I understand that I am financially responsible for services that may not be covered under my health insurance policy or third-party payments except where contrary to law. I understand that it is my responsibility to pay for all charges not covered by my insurance company (including deductibles and co-payments). Facility offers a financial assistance program for qualified patients who cannot pay the full portion of their bill. [Add contact #].

B. Receiving services at a designated provider-based office is the same as receiving services from one of Facility's affiliated hospitals. I understand that separate billing may be issued for both the services of the

Facility and the services of the healthcare professionals, and that neither's charges are included in the billings of the other.

IV. ADDITIONAL ACKNOWLEDGMENTS

A. **Communication Methods**: I agree that Facility and its business associates may contact me by any phone number provided by me or associated with my health record. Facility may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device. I understand that I can choose not to participate in some or all these methods by completing an opt out form.

B. **No Tolerance for Violence. I acknowledge that Trinity Health has a "Zero Tolerance for Violence" policy**. *This applies to all patients, colleagues, volunteers, and visitors. I understand that incidents may result in removal from the facility, dismissal from the practice and potential criminal prosecution.*

C. **Chaperone:** I understand that Facility allows for a chaperone during my visit, and I will let my Provider, or the Facility staff know if I would like a chaperone present.

D. **Missed Appointment Policy:** I acknowledge that Facility has a missed appointment policy and that I may request the policy for review. I agree to notify the office as soon as possible if unable to keep a scheduled appointment time.

E. **Photography or Recording:** I consent to photography or videotaping of my care and the procedures performed, including appropriate portions of my body, as the Facility or Provider determines will benefit my care, and for quality improvement, scientific research, or educational purposes, provided my identity is not revealed by the pictures or by the descriptive text accompanying them. If the photographs, or recordings identify me in any way and are used for my care, those recordings will be retained by as part of my health record

F. **Personal Valuables**: I understand that Facility does not accept responsibility for any lost, stolen, or damaged personal items while I am at the office.

G. **Telemedicine Services**: I understand that I may receive care through telemedicine services. Telemedicine is the use of medical and personal information exchanged between clinician and patient via electronic communications and technology to improve a patient's health status.

THE PURPOSE OF THIS FORM WAS EXPLAINED TO ME AND I HAD THE OPPORTUNITY TO ASK QUESTIONS

Print Patient Full Name		Patient Date of Birth
Patient Signature	Date	Time

If patient is a minor or adult under guardianship, parent or legal guardian must sign

Signature of Parent or Legal Guardian	Date	Time

Print Name and Relationship to Patient. Describe authority to sign on behalf of patient