Encore Geriatrics

New Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient Home Phone Number: _____ Alternate Number (☐ cell or ☐ work): _____

E-Mail Address:_____

Facility Name: _____ ☐ Assisted Living ☐ Memory Care ☐ Independent Living

Address: _____ Apt #_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Age:_____ Sex:_____ Social Security Number:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

Name of Patient Power of Attorney/Guardian : _____ Phone Number: _____

BILLING ADDRESS /CONTACT (Skip if billing address is same as patient address)

Name: _____ Relationship to patient: _____

Address: _____ Phone Number:_____

INSURANCE INFORMATION

Primary Insurance:_____ ☐ PPO ☐ HMO (If HMO please change PCP to Dr. Andrew Colman)

Policy Number:_____ Group Number:_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

INSURED INFORMATION (IF OTHER THAN PATIENT):

Subscriber/ Policy Holders: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

(**PLEASE ATTACH COPY OF INSURANCE CARDS** (front and back) and include Medicare Card)

Patient or Guardian Signature:_____ Date:_____

Patient Acknowledgement Form

Patient Acknowledgement of Understanding of Encore Geriatrics, L.L.C. Privacy Practices. I understand that the patient's health information is private and confidential. I understand that Encore Geriatrics work very hard to protect the patient's privacy and preserve the confidentially of the patient's personal health care information.

I understand that Encore Geriatrics may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Encore Geriatrics has a detailed document called the "Notice of Privacy Practice". It contains more information about the polices and practice protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "notice" before signing this Acknowledgement.

Encore Geriatrics may update this Acknowledgement and "notice of Privacy Practice". If I ask, Encore Geriatrics will provide me with the most current "Notice of Privacy Practice".

Within this Notice of Privacy Practice is contained a complete description of my privacy / confidentiality rights. These rights include, but aren't limited to, access to my medical records; restriction on certain uses; receiving on accounting of disclosure as required by law; and requesting communication be by specified methods of communications or alternative location.

Encore Geriatrics have established procedures which help them meet their obligations to patients. These procedures may include other signature requirement, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Encore Geriatrics by following these procedures if I choose to exercise any of mt rights described in the "Notice of Privacy Practice".

_____ _____ _____

Patient or Legally Authorized Individual Date Time

_____

RELATIONSHIP TO PATIENT IF SIGNED BY ANYONE OTHER THAN THE PATIENT (PARENT, GUARDIAN, PERSONAL REPRESENATIVE, ETC)

Name of primary individual we may release information to regarding your care and their relationship: _____

_____

Address of individual _____

Phone Number of Individual _____

Additional individuals and relationship _____

_____

HIPAA Notice of Privacy Practices

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. If you have any questions about this notice, please contact Encore Geriatrics staff member.

Your medical information is personal. Encore Geriatrics is committed to protecting your medical information. We create a record of the care and services you receive and we need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your medical care generated by Provider.

This Notice will tell you the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

Provider is required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
3. Follow the terms of the Notice that is currently in effect.

HOW PROVIDER MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:

The following describes the different ways that your medical information may be used or disclosed by Provider. For clarification, we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

- **For Treatment:** We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other providers who are involved in providing you medical treatment.

- **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive from Provider may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations:** We may use and disclose medical information about you for Provider's operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of Provider in caring for you. We may also combine medical information about many of our patients to decide what additional services Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other Provider personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

- **Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care from Provider.

- **Treatment Alternatives:** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services:** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

- **As Required By Law:** We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Health Oversight Activities:** We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may use your medical information to defend Provider or to respond to a court order.

- **Law Enforcement:** We may release medical information about you if required by law when asked to do so by a law enforcement official.

- **Coroners and Medical Examiners:** We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

- **Fundraising:** We may contact you regarding fundraising events or opportunities. If you receive communications regarding fundraising, and you do not wish to receive such communications, you may opt out at that time.

REQUIREMENT OF YOUR WRITTEN AUTHORIZATION

- **Marketing:** We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

- **Psychotherapy Notes:** If any services that we provide include psychotherapy, any notes created and maintained pursuant to these services will not be released without your written authorization.

- **Other Uses of Your Information:** Other uses and disclosures of your health information that are not otherwise described in this Notice of Privacy Practices will only be made with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights regarding the medical information Provider maintains about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To inspect and copy your medical information, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review, contact the Privacy Officer.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost-based fee limited to the labor costs associated with transmitting the electronic health record.

- **Right to Amend:** If you feel that medical information we have about you 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 Provider. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us;
2. Is not part of the medical information kept by Provider;
3. Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures Provider has made of your medical information. We are not required to list certain disclosures, including disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations; however, if these disclosures were made through an electronic health record, you have the right to request, beginning on dates established by law or regulation, an accounting for such disclosures that were made during the previous 3 years.

To request this accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 4, 2003.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the use or disclosure we make of your medical information.

We are not required to agree to your request for a restriction, except as noted below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We are required to agree to your request for a restriction if, except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment or health care operations (and is not for purposes of carrying out treatment) and the medical information pertains solely to a health care item or service for which we have been paid out of pocket in full.

You have the right to restrict certain disclosures of your PHI to your health plan if you elect to pay out of pocket in full for the health care services provided.

To request restrictions, you must make your request in writing to the Privacy Officer.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate all reasonable requests.

- **Right to a Paper Copy of this Notice:** You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact the Privacy Officer.

- **Right to Receive Notice of a Breach:** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include specified information, including a brief description of the breach, including the date of the breach and the date of its discovery, if known; a description of the type of Unsecured Protected Health Information involved in the breach; steps you should take to protect yourself from potential harm resulting from the breach; a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches; contact information, including a toll-free telephone number, email address, Website or postal address to permit you to ask questions or obtain additional information.

REVISIONS TO THIS NOTICE: We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice at Provider's facilities. Any revised Notice will contain on the first page, in the bottom right hand corner, the effective date.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Provider or with the Secretary of the Department of Health and Human Services. To file a complaint with Provider, please submit in writing and send to:

PROVIDER WILL IN NO WAY PENALIZE YOU FOR FILING A COMPLAINT

Effective Date: 1/2018

Provider HIPAA Notice of Privacy Practices Acknowledgement Form

I acknowledge that I have been provided with Encore Geriatrics's Notice of Privacy Practices ("Notice"):

- It tells me how Provider will use my health information for the purposes of treatment, payment for my treatment, and Provider's healthcare operations.
- The Notice explains in more detail how Provider may use and share my health information for other than treatment, payment and health care operations.
- Provider will also use and share my health information as required/permitted by law.

Patient's Full Legal Name	**Date of Birth**
Signature of Patient/Legal Representative	**Date**

Documentation of Failure to Obtain Signed Acknowledgement

On _____ (date), _____ (employee name) presented this Acknowledgment of Receipt of Notice of Privacy Practices form to _____ (the "Patient"). The Patient refused to provide a signature when requested.

BLOOMFIELD 79460-4 2190481v1

Encore Geriatrics

MEDICAL INFORMATION:

Please complete this form to your best abilities.

Personal Medical History: Have you ever had any of the following conditions? (check if yes)

□ Anemia □ Arthritis □ Asthma □ Cancer- type_____ □ Chronic Obstructive Pulmonary Disease □ Clotting Disorder- Type_____ □ Congestive Heart Failure □ Crohn's disease □ Covid 19 Infection	□ Depression □ Diabetes- Type_____ □ Emphysema □ Hypertension □ Hypothyroidism □ Hyperthyroidism □ GERD □ Glaucoma □ Hepatitis	□ HIV/ AIDS □ Kidney Disease □ Macular degeneration □ Myocardial Infarction □ Peptic Ulcer Disease □ Seizures □ Stroke □ Ulcerative Colitis

Other:_____

_____

Personal Surgical History: Have you ever had any of the following surgeries? (check if yes)

□ Adrenal Gland Surgery □ Appendectomy □ Bariatric Surgery □ Bladder Surgery □ Breast Surgery □ Cesarean Surgery □ Cholecystectomy (gall bladder)	□ Colon Surgery □ Coronary Artery Bypass graft □ Esophagus Surgery □ Heart Stent □Hemorrhoid □ Hernia Repair □ Hysterectomy	□ Kidney Surgery □ Neck Surgery □ Prostate Surgery □ Small Intestine Surgery □ Spine Surgery □ Stomach Surgery □ Thyroid Surgery □ Tonsillectomy

Other:_____

_____

ALLERGIES: □ No Known Drug Allergies

Allergies (List allergies with reaction):_____

_____

Family History: Unknow family history: □-

Mother: □ Alive □ Deceased- age_____ Diagnosis_____

Father: □ Alive □ Deceased- age_____ Diagnosis_____

Maternal Grandma: □ Alive □ Deceased- age_____ Diagnosis_____

Maternal Grandpa: □ Alive □ Deceased- age_____ Diagnosis_____

Paternal Grandma: □ Alive □ Deceased- age_____ Diagnosis_____

Paternal Grandpa: □ Alive □ Deceased- age_____ Diagnosis_____

Child □ Alive □ Deceased- age_____ Diagnosis_____

Child □ Alive □ Deceased- age_____ Diagnosis_____

Other_____

Medication List (including prescriptions, vitamins, herbals, and over the counter medications):

Medication Name	Dosage	Direction

****If additional medication are taken please use back of page or attach medication list

Preferred Pharmacy Name:_____ Address:_____ Phone Number:_____

Social History:

Tobacco use: □ Never □ Former Tobacco Smoker □ Smokeless □ Second Hand Smoke □ Cigars □- chews tobacco □ current

Number of Years tobacco use:_____ Amount of cigarette's per day:_____

Alcohol use: □ Never □ Yes – Type:_____ Amount of alcohol:_____ per □ day, □ week, □ Month

Drug use: □ Never □ Yes: Type:_____ □ Former: Type _____

Immunization:

Influenza vaccine- □ refused □ up to date- Date of shot_____

Pneumococcal 23 vaccine- □ refused □ up to date- Date of shot_____

Prevnar 13- □ refused □ up to date- Date of vaccine_____

Prevnar 20- □ refused □ up to date- Date of vaccine_____

Shingrix - □ refused □ up to date- Dates of vaccine(s)_____

Tetanus- □ refused □ up to date- Date of vaccine_____

Covid vaccine- □ refused □ up to date- Date(s) of vaccine & manufacture_____

RSV vaccine-□ refused □ up to date- Date of vaccine_____

Preventative Health:

Physical Exam: Date of last Physical: _____ Name of Previous PCP:_____

Date of Last Blood Work:_____

Mammogram: □ patient refused □ up to date date completed_____

Test Location _____ Results: □ normal □ abnormal □ not applicable

Bone Density: □ refused □ up to date date completed_____

Test Location _____ Results: □ normal □ abnormal □ not applicable

Colonoscopy: □ refused □ up to date date completed_____ Test location_____

Results of Colonoscopy: □ normal abnormal : □ polyps □ Hemorrhoids □ other-_____

Advised to repeat test in □ 10 years □ 5 years □ 3 years □ 2 years □ 1 year

Cologuard: □ refused □ up to date date completed_____ Results: □ normal □ abnormal

Pap Smear: □ refused □ up to date date completed_____ Test Location _____

Results: □ normal □ abnormal □ not applicable

Prostate Exam: □ refused □ up to date date completed_____

Test Location _____ Results: □ normal □ abnormal □ not applicable

Height: _____

Current weight: _____lbs

MEDICAL CONCERNS:

Please list any medical concerns you or your family or friends may have: _____
_____

_____

_____

_____

Preferred Health Care System:_____
Any Recent Hospitalization (please include dates, hospital, and diagnosis: _____
_____
_____
_____

Encore Geriatrics

TELEMEDICINE CONSENT FORM

I _____ wish to have a telemedicine consultation with Dr. A. Colman/ Jodie Colman NP/ Star Burke NP/ Robert Louis-Ferdinand NP/ Jenna Mckeever NP/ Cara Peterson NP. This means that I, and/or staff at Encore Geriatrics will through interactive audio and video connections be able to consult with the above named Healthcare Provider about my condition.

My Healthcare Provider, and/or Long Term Care Facility, has explained to me, or my guardian, how the telemedicine technology will be used to do such a consultation.

I understand there are potential risks with this technology. For example: The video connection may not work or that it may stop working during the consultation, or the video picture or information transmitted may not be clear enough to be useful for the consultation. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. I may be required to go to the location of another physician, if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis.

I give my consent to be treated by the Healthcare Provider via telemedicine. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and other applicable laws.

I also give consent to receive a "virtual check-in", which allows for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. These virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).

I understand that a limited physical examination will take place during the telemedicine session, and that I have the right to ask my Healthcare Provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the Healthcare Provider.

I understand that the insurance coinsurance and deductibles would generally apply to these services.

I authorize the release of any relevant medical information about me to the Healthcare Provider, any staff the Healthcare Provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes.

I hereby release Nursing Facility Assisted Living Facility or Long term Care Facility, its personnel and any other person participating in my care from any and all liability which may arise from the authorized use of videotapes, digital recording films and photographs.

I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the conditions described in this document.

_____	_____	_____
Patient/legal representative signature	Relationship	Date/time
_____	_____	
Witness	Date/time	

Encore Geriatrics

Authorization for Release of Health Information

Please complete the section below:

Section 1: Patient Information (please print):

Last name:	First Name:	Middle Name:	Previous names used:
Date of Birth:	Last four digit of social security number:	Email Address:	
Street Address:	City:	State:	Zip code:
Home Phone Number:		Cell Phone Number:	

Section 2: Facility/ Office where you received medical Care:

Facility Name:			
Street Address:	City:	State:	Zip code:
Office Phone Number:		Office Fax Number:	

Section 3: Specific health information to be related or disclosed. Chose one option

☐ Summary (Physician reports, labs, & test results) for dates of service from: _____ to _____

☐ Complete copy of my medical Records for dates of service from: _____ to _____

☐ Other (please describe):_____

Section 4: Purpose of request/ disclosure

☐ continuation of care ☐ new primary care provider ☐ legal ☐ other, please specify:_____

Section 5: Where would you like your information sent? Choose one.

☐ Release to Encore Geriatrics 6149 Wayne Road Westland Mi 48185 Fax # 734-728-1433

☐ Release to:

Name:			
Street Address:	City:	State:	Zip code:
Office Phone Number:		Office Fax Number:	

Encore Geriatrics

Westland Health Care
A Division of Michigan Healthcare Professionals, P.C.

Section 6: Signature of Patient or Patient Representative

By signing this Authorization, I hereby request and authorize that Westland Health Care and its agents and employees, or other health care provider, release the following Protected Health Information or to request medical records from another facility or health care provider. I understand the following:

- My Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
- My Health Information may include information about behavioral or mental health services, treatment for alcohol and drug abuse.
- This Authorization is voluntary. My treatment will not be impacted even if I do not sign this Authorization.
- This Authorization is valid for one year from the date that I signed unless another date is listed below.
- I may revoke or withdraw this Authorization, except to the extent that action has been taken prior to the receipt of the revocation or withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal or state privacy laws, and could be re-disclosed by the person(s) receiving it.
- If I am not making this request in person, I may be asked to provide a copy of my current driver's license or state identification.
- There may be a fee associated with my request.
- This release is being made at my request.

Signature: _____ Date:_____

Witness Signature:_____ Date:_____