Welcome! All of us at Born Clinic, P.C. (Born Clinic) are looking forward to seeing you as a new patient.

At the time of your first visit, please bring completed forms, along with paper copies of your *most recent* blood tests, biopsies, MRIs, ultrasounds, mammograms, cardiac tests, or any other test results that are relevant to your upcoming visit to Born Clinic. Please do not bring the results on a disk; we do need the results on paper. If you experience difficulty in obtaining copies, feel free to give us a call – we may be able to assist you.

Also, please bring a list of your current medications and nutritional supplements. If it is easier to bring the actual bottles, please do so.

If you have any questions, you may call us at 616-656-3700. Thank you.

Sincerely,

The Staff at Born Clinic

3700 52nd Street SE • Grand Rapids, MI 49512 • 616-656-3700
www.bornclinic.com

Date: _____

Welcome to Born Clinic! Please tell us: How did you first learn of our Clinic?

☐ Born Clinic website ☐ Sign outside building ☐ Friend or Family Member: _____

☐ Healthcare Provider: _____ ☐ Book: _____ ☐ Other: _____

Patient Name: _____ **Age:** _____ **Marital Status:** _____

Responsible Party: _____ **Relationship to Patient:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Important: *Born Clinic may need to call you to remind you of an appointment, provide test results, or make recommendations.*

Primary Phone: _____
☐ Cell ☐ Home ☐ Work ☐ Other: _____

Secondary Phone: _____
☐ Cell ☐ Home ☐ Work ☐ Other: _____

I consent to receive calls from Born Clinic for my protected healthcare and other services at the phone numbers provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. _____
Patient or Guardian Signature

Family Information, <u>including</u> patient:

First Name:	M.I.	Last Name:	Sex:	DOB:	Employer:

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Allergies to any medications: _____

Surgeries: _____

Allergy to Latex: ☐ Yes ☐ No **Date of most recent colonoscopy:** _____ **Date of most recent bone density:** _____

***Women*: Date of most recent pap smear:** _____ **Date of most recent mammogram:** _____ **Dense Breasts:** ☐ Yes ☐ No

Medications taken on a daily basis: _____

_____

Major medical problems: _____

_____

_____

BORN CLINIC FINANCIAL POLICY

Every effort is made to ensure that a visit to Born Clinic is a pleasant experience. We believe patients have a right to know, and that the Clinic has an obligation to provide, complete information about fee schedules and payment requirements. Unless you have Medicare* or prior arrangements have been made for you, we appreciate total payment at the time services are rendered. Payment may be made by cash, check, or credit card and you will be given an encounter form that you may send to your insurance company.

Born Clinic bills most Medicare plans but does not otherwise routinely file insurance claims. While we will cooperate to the fullest in providing you with accurate information so that you may bill your insurance company, you remain fully responsible for your account. If you have any questions regarding our financial policy, please feel free to speak with a receptionist or billing manager.

Patient Signature: _____ **Date:** _____

Insurance Information: ***If you are covered by more than one insurance company, please supply information from both carriers.***

Name of *Primary* Insurance:	Name of *Secondary* Insurance:
Name of the Insured (name on ID card):	Name of the Insured (name on ID card):
Insured's Date of Birth:	Insured's Date of Birth:
Patient's relationship to the insured: ☐ Self ☐ Spouse ☐ Child	Patient's relationship to the insured: ☐ Self ☐ Spouse ☐ Child
Insured ID#:	Insured ID#:
Group # or Company Name:	Group # or Company Name:
Please note: Our office does not file claims for Auto Accidents or Workers' Compensation.	
I authorize the release of my medical information or any other information necessary to process my claim(s): **Patient or Authorized Person's Signature:** _____ **Date:** _____	

Medicare Patients Only: We are participating physicians with traditional Medicare and Medicare Plus Blue PPO. We are out of network for all other Medicare plans. We will file all covered Medicare services for you and accept Medicare's allowable charge. We will bill you for any deductible and co-pays that you are responsible for. If you or your spouse are employed and have coverage through an employer, Medicare may be your secondary insurance. Born Clinic must know which insurance is primary and which is secondary.

I,_____ (*patient name*), hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided at Born Clinic, P.C., on or after this date by Tammy L. Born, D.O.; Dorothy A. Pedtke, D.O.; Mitchell A. Cohn, D.O.; Kayla R. Licari, P.A.-C.; Robert E. Miller, P.A.-C.; Rachal L. Rossi, NP, and their associates, may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that my insurance coverage, including Medicare, will not pay for such non-covered services, and I will be personally responsible for payments to the Born Clinic for such non-covered services.

I authorize payment of medical benefits be made on my behalf to Born Clinic, P.C., for any services furnished to me by Born Clinic. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Witness: _____ Date: _____

*We do **not** participate with all Medicare plans. **Please note that Mitchell Cohn, D.O. is an out of network provider with Medicare Plus Blue PPO.** Please ask the receptionist or billing manager if you have any questions.

Authorization to Discuss Medical Information

Patient Name: _____ DOB: _____

Your medical information is confidential. Occasionally, it may be helpful or necessary for us to speak with a family member or friend on your behalf regarding an appointment, medications, test results, or to share medical advice. **Please note that this is not an authorization to release medical records.** In order to release a copy of your medical records, you will need to complete a separate records disclosure form.

I give Born Clinic permission to discuss my protected health information with the following person(s). This authorization will remain in effect until I withdraw my permission in writing to Born Clinic, attention office manager. I am entitled to a copy of this form upon my request.

Name:	Relationship:	Phone Number:

Patient/Guardian Signature: _____ Date: _____

Preventive Health Care Recommendations Form

Dear Patients,

The providers at Born Clinic are always striving to bring you the best in preventive care. Therefore, we would like to remind you that certain health examinations and screenings are recommended on a regular basis. Most of these examinations can be done at our office. Please review the recommendations below and then speak to your provider about which ones are right for you. In addition, please fill out the Medical History Review form.

Recommended Periodic Health Examinations for Men and Women:

Age:	Recommended Screening:	Frequency:
18 Years & Older	Blood Pressure, Height, Weight, Nutritional and Toxicity Evaluation	Periodically or as recommended by your physician
35 Years & Older (or earlier if risk factors)	Lipid Profile, Thyroid Profile, Inflammation Markers, Blood Chemistry Profile, Complete Blood Count	Yearly, or more if abnormal or at high risk
40 Years & Older	ECG	Yearly or every other year
50 Years & Older	Sigmoidoscopy or Colonoscopy	Every 5-10 years, or as determined by risk factors

Recommended Periodic Health Examinations for Women:

Age:	Recommended Screening:	Frequency:
25 Years & Older (or younger if sexually active)	Pap, Pelvic and Breast Exam Self Breast Exam	Every year, especially if taking hormones Monthly
40 Years & Older (or at age 35 if strong family history of breast cancer)	Mammography, Thermography, or Breast MRI	Every 1-2 years, yearly if taking hormones
45-50 Years (or earlier if menopausal or family history)	Bone Density Measurement	Every 1-2 years

Recommended Periodic Health Examinations for Men:

Age:	Recommended Screening:	Frequency:
50 Years & Older	PSA Blood Test Prostate Exam Bone Density Measurement	Yearly Yearly Every 1-2 years

Medical History Review

Patient Name: _____ DOB: _____

Personal Medical History:

Please check all that apply to past and present medical conditions (*if checked, please note onset/type*):

☐ Anemia/Blood Disorder/Clots _____
☐ Arthritis _____
☐ Autoimmune Disease _____
☐ Breast Issues/Dense Breasts _____
☐ Cancer _____
☐ COPD/Emphysema/Asthma _____
☐ Dementia/Alzheimer's _____
☐ Depression/Anxiety _____
☐ Diabetes _____
☐ Digestive Issues/IBS _____
☐ Enlarged Prostate _____
☐ GERD (Acid Reflux) _____
☐ Glaucoma/Other Eye Problems _____
☐ Heart Attack _____
☐ Heart Disease/CHF/CAD _____
☐ Heart Murmur/Arrhythmia _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ HIV ☐Hepatitis ☐TB _____
☐ Kidney Disease _____
☐ Liver Disease _____
☐ Lyme Disease _____
☐ Menopause/Andropause _____
☐ Migraines/Headaches _____
☐ Neuropathy _____
☐ Osteoporosis _____
☐ Peripheral Vascular Disease _____
☐ PMS/Heavy/Painful Menses/Fibroids _____
☐ Sleep Apnea/Insomnia _____
☐ Stroke _____
☐ Thyroid Disease _____
☐ Other (please specify) _____

Family Medical History (Grandparents, Mother, Father, Siblings): ☐ Unknown Family History

Please check all that apply to family medical history (*if checked, please specify which relative*):

☐ Arthritis _____
☐ Autoimmune Disease _____
☐ Cancer _____
☐ COPD/Emphysema/Asthma _____
☐ Dementia/Alzheimer's _____
☐ Depression/Anxiety _____
☐ Diabetes _____
☐ Glaucoma/Other Eye Problems _____
☐ Heart Attack _____
☐ Heart Disease/CHF/CAD _____
☐ Heart Murmur/Arrhythmia _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Liver Disease _____
☐ Osteoporosis _____
☐ Peripheral Vascular Disease _____
☐ Stroke _____
☐ Thyroid Disease _____
☐ Other (please specify) _____

Social History/Habits:

Tobacco Use? ☐Quit ☐Yes ☐No If yes, how much? _____ How often? _____
Alcohol? ☐Yes ☐No If yes, how much? _____ How often? _____
Caffeine (coffee/soda)? ☐Yes ☐No If yes, how much? _____ How often? _____
Recreational Drugs? ☐Yes ☐No If yes, how much? _____ How often? _____
Do you exercise? ☐Yes ☐No If yes, how much? _____ How often? _____
Diet/Eating Habits (balanced, poor, vegetarian, gluten free, etc.): _____

I have read and understand the Preventive Health Care Recommendations Form. I will take the appropriate action to make arrangements for the necessary exams.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Preferred Pharmacy:

Pharmacy Name: _____ Phone Number: _____

Address: _____

*If phone number and/or complete address are unknown, please provide street name and city.

Primary Care Physician:

Name: _____ Phone Number: _____

Address: _____

Specialty Physician (Cardiology, Urology, etc.):

1. Name: _____ Phone Number: _____

Address: _____

Specialty: _____

2. Name: _____ Phone Number: _____

Address: _____

Specialty: _____

3. Name: _____ Phone Number: _____

Address: _____

Specialty: _____

Born Clinic, P.C.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Office Manager, Born Clinic, 3700 52nd St SE, Grand Rapids, MI 49512 or 616-656-3700.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in the billing and collection efforts.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION IN THE FOLLOWING WAYS Continued:

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.
5. **Phone Calls.** Our Practice may use and disclose your IIHI to contact you and schedule an appointment, remind you of an appointment, reschedule an appointment, or to notify you of test results.
6. **Appointment reminder notices in the mail.** Our practice may send you a note by U.S. mail to remind you of upcoming appointment(s) or to notify you the practitioner recommends an appointment.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigation, inspections, audits, surveys, licensure and disciplinary actions; civil administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) if required by the appropriate authorities.
7. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosures for these purposes may be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
9. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Born Clinic Office Manager, 3700 52nd Street SE, Grand Rapids, MI 49512 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests.
2. **Requesting Restrictions.** You have the right to request a restriction in our use of disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Born Clinic Office Manager, 3700 52nd Street, SE, Grand Rapids, MI 49512. Your request must describe in a clear and concise fashion:

    (a) the information you wish restricted;
    (b) whether you are requesting to limit our practice's use, disclosure or both; and
    (c) to whom you want the limits to apply.

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Born Clinic Office Manager, 3700 52nd Street SE, Grand Rapids, MI 49512 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Born Clinic Office Manager, 3700 52nd Street SE, Grand Rapids, MI 49512. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Born Clinic Office Manager, 3700 52nd Street SE, Grand Rapids, MI 49512. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Office Manager, Born Clinic, 3700 52nd Street SE, Grand Rapids, MI 49512 or call 616-656-3700.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services . To file a complaint with our practice, contact Born Clinic Office Manager, 3700 52nd Street SE, Grand Rapids, MI 49512. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time <u>in writing</u>. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

BORN CLINIC
3700 52nd Street SE
GRAND RAPIDS, MI 49512

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I have received a copy of Born Clinic's *Notice of Privacy Practices*.

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Signature: _____

Today's Date: _____

If signed by a personal representative:

Name of personal representative: _____

Signature of personal representative: _____

Relationship: _____

Today's Date: _____

Born Clinic Employee Witness Signature: _____