PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

HAMTRAMCK COMMUNITY MEDICAL CENTER, P.C.

GENERAL CONSENT TO TREATMENT

Patient Name: _____

Physician: _____

REQUEST AND CONSENT TO AMBULATORY SERVICES

By signing this form, I am requesting and consenting to ambulatory and office services as the physician or his designees (physician) believe necessary for the patient. These services include, without limitation, routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical, nursing and ambulatory care. I know that in emergencies the physician may believe it necessary to expand or deviate from the services. I request and consent to these expanded and/or different services and procedures as the physician may think best for the health of the patient. I also consent to the Health Center personnel doing the things they would normally do in caring for a patient, and as instructed by the physician. I understand that the Health center may perform non-diagnostic test on the patients blood, urine and other bodily fluids/tissues that were drawn for diagnostic purposes, and the Health Center may dispose of these specimens as it chooses. I understand this General Consent to Treatment (entire form) will remain in effect until such time as I cancel (revoke) it in writing.

NO GUARANTEES

I understand medicine is not an exact science and that diagnostic and treatment involve risks. No one can or has given me a guarantee or promise of what the results of the patient's diagnostic, treatment and care will be.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING

I understand that the Health Center may perform an HIV test upon the patient without any special written consent if a health professional or employee at the Health center has a percutaneous, mucus membrane, or open wound exposure to the patient's blood or other body fluids.

RELEASE OF INFORMATION

I authorize the Health Center to release information from the patient's medical record, including:

- Information about communicable diseases and serious communicable diseases and infections as defined by statue and Michigan Department of Public Health Rules (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS" and AIDS related complex "ARC".

- substance abuse treatment information protected by 42 Code of Federal Regulations Part 2

- psychological and social services information including communications made by me to a psychologist or social worker to:

(a) any third party payor or insurance company (including Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans) which are responsible in whole or in part for paying my Health Center bill so that the Health Center may be paid for its services;

(b) any health care facility of physician to which I am transferred for continuity of care; and

(c) any independent auditors or reviewers retained by any third party payor, private health insurer or any employer providing health insurance benefits to me so that these independent auditors can analyze Health Center charges.

(This is a two-sided form. Be sure to read both sides before you sign)

HAMTRAMCK COMMUNITY
MEDICAL CENTER, P.C.

Name _____ Date _____

Birth Date _____ Age _____ Social Security # _____

Please list all allergies to food and medicine _____

_____

Please indicate if you now have or have had the following medical conditions:

	No	Yes		NO	Yes		No	Yes
Tuberculosis - T.B.	____	____	High Blood Preasure	____	____	Diabetes	____	____
Chest Pain	____	____	Asthma	____	____	Hemorrhoids	____	____
Chronic Cough	____	____	Alcoholism	____	____	Glaucoma	____	____
Low Blood Pressure	____	____	Migrane	____	____	Heart Attack	____	____
Edema	____	____	AIDS	____	____	Obesity	____	____
Bleeding Discorders	____	____	Cancer	____	____	Venereal Disease	____	____
Seizers	____	____	Constipation	____	____	Kidney Stones	____	____
Rheumatic Fever	____	____	Hypoglycemia	____	____	Thyroid Disorders	____	____
Arthritis	____	____	Emotional (Nerves)	____	____			

Other _____

_____

List all medications you are currently taking: _____

My last tetanus shot was _____ Flu shot _____ Pneumovax _____ Other _____

I eat meals: _____ Regularly _____ Irregularly

Describe usual: Breakfast _____

Lunch _____

Dinner _____

Snacks _____

I exercise (note type and frequency) _____

Present weight _____ Highest weight _____

I wear seat belts while driving _____ Always

_____ Usually

_____ Often

_____ Occasionally