PETOSKEY FAMILY MEDICINE, P.C.

SCOTT HOTCHKISS, M.D.
SAMUEL MINOR, M.D.
SARAH WADOWSKI, PA-C
CAROLYN WIESE, PA-C

1890 U.S. 131 South, Suite #3
Petoskey, Michigan 49770
Telephone: (231) 487-6000
Fax: (231) 487-6014

Dear Patient,

Thank you for choosing Petoskey Family Medicine, P.C. for your healthcare needs. We appreciate the opportunity and look forward to serving you.

Enclosed you will find our new patient paperwork. We ask that you complete the paperwork and either return it to us in the mail, fax, or bring it into the office. After we have received your records and reviewed your information, we will contact you to schedule an appointment.

If you have any questions, feel free to call our office Monday through Friday, 9 a.m. to 5 p.m.

Again, thank you for your interest in Petoskey Family Medicine.

Sincerely,

Scott Hotchkiss, M.D.
Samuel Minor, M.D.
Sarah Wadowski, PA-C
Carolyn Wiese, PA-C

Petoskey Family Medicine, P.C.

Patient Demographics

Last Name: _____ First: _____ MI: _____

Sex: Male Female Birthdate: _____

Marital Status: Single Married Divorced Widowed

Email Address: _____

Spouse/Parent Name & Birthdate: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell: _____

Employer: _____ Phone: _____

Insurance Provider: _____

Subscriber Name and Birthdate: _____

Contract Number: _____

Group Number: _____

Preferred Provider: Sarah Wadowski, PA-C Carolyn Wiese, PA-C

I certify that the information provided is correct and that I will notify Petoskey Family Medicine of any changes.

Signature: _____ Date: _____

Release of Medical Records

I, _____ authorize the release of my medical records
Name Birthdate

From:

_____ Address: _____

_____ Address: _____

To: Petoskey Family Medicine, P.C.
1890 U.S. 131 South
Petoskey, MI 49770
Fax: 231-487-6014

_____ Scott Hotchkiss, M.D.
_____ Samuel Minor, M.D.
_____ Carolyn Wiese, PA-C
_____ Sarah Wadowski, PA-C

Specific type of information to be disclosed and dates of service:

_____ Any information related to my care for _____
_____ Progress Notes _____
_____ Discharge Summary _____
_____ History & Physical _____
_____ Operative Report/Pathology _____
_____ X-Ray/Lab _____
_____ Drug Testing _____
_____ Employment Physical _____
_____ Referral Physician/Hospital Records _____
_____ Other _____

Purpose and need for such disclosure:

_____ Continuation of treatment or health care follow up
_____ Billing Information
_____ Social Service Referral
_____ Disability Determination
_____ Workers Compensation
_____ Other

This authorization is subject to written revocation at any time to the extent that Petoskey Family Medicine has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of the signature. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPPA Privacy Standards. My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.

Signature of Patient _____ Date _____

Authorized Representative _____ Date _____

Witness (if required) _____ Date _____

HIPAA – Notice and Acknowledgement

Petoskey Family Medicine

1890 U.S. 131 South, Petoskey, MI 49770

I acknowledge that I have read and understand the following documents. By initialing each and then signing below I agree to:

1. Authorize Petoskey Family Medicine (PFM) to make referrals on my behalf and share relevant clinical and demographic information as outlined in the **HIPAA PATIENT CONSENT FORM AND THE PRACTICE PRIVACY DOCUMENT.** Initial: _____
2. The **RETRIEVAL OF PRESCRIPTION HISTORY** via the Prescription Benefits Manager (RxHub) and to the submission of electronic prescriptions to my preferred pharmacy. Initial: _____
3. Authorize PFM to record my immunization history with the **MICHIGAN CARE IMPROVEMENT REGISTRY.** Initial: _____
4. Authorize **RELEASE OF INFORMATION** regarding my medical treatment when requested by my insurance carrier and authorize assignment of benefits directly to PFM for the provision of surgical and medical benefits. **I acknowledge that I am responsible to pay non-covered services as outlined in the FINANCIAL POLICY.** Initial: _____
5. I authorize PFM to leave information on my answering machine about my healthcare including appointments, test results, and other messages. Initial: _____
6. **RELEASE OF MEDICAL INFORMATION:** I authorize PFM to speak to the below individuals regarding my medical care.

   A. _____ Phone: _____
   Relationship: _____

   B. _____ Phone: _____
   Relationship: _____

Patient Name (print): _____ D.O.B. _____

Patient Signature: _____ Date: _____

Retrieval of Prescription History

Petoskey Family Medicine

1890 U.S. 131 South, Petoskey, MI 49770

The Prescription Benefit Manager gives us the ability to review our prescription coverage and medication history. There are three processes working together to provide us with this data.

Prescription Eligibility: Retrieves your latest prescription benefit information, including whether your plan has mail-order benefits.

Retrieved Medication History: Displays a list of all your medications based on claims made against your prescription plan. Although this may not provide an up-to-the-minute list, it does give us an overall view of your medication history.

Real-Time Formularies: Provides a list of preferred drugs that are covered by your current prescription plan.

Electronic Prescriptions

The Prescription Benefit Manager gives us the ability to electronically prescribe,

"e-scribe", most of your medications to local and mail-order pharmacies. Electronic prescriptions give your provider the ability to electronically send accurate, clearly defined prescriptions directly to your pharmacy.

Should you prefer a hard copy/paper prescription, you will need to notify us on a visit-by-visit basis. Otherwise, all medications will be e-scribed to our preferred pharmacy.

Please initial and sign the NOTICE AND ACKNOWLEDGEMENT form to verify that you have read and understand this document.

Michigan Care Improvement Registry (MCIR)

Petoskey Family Medicine

1890 U.S. 131 South, Petoskey, MI 49770

The immunization registry has been established to transmit immunization information from Petoskey Family medicine to the Michigan Care Improvement Registry or MCIR (previously known as Michigan Childhood Immunization Registry). By consolidating immunization records into a statewide electronic record, all providers with access to MCIR can take appropriate steps to reduce vaccine preventable disease in our most valuable citizens and help with the over or under immunization of our patients.

Please initial and sign the NOTICE AND ACKNOWLEDGEMENT form to verify that you have read and understand this document.

HIPPA Notice of Privacy Practices

Petoskey Family Medicine

1890 U.S. 131 South, Petoskey, MI 49770

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you that includes demographic information that may identify you and that relates to your past, present, and future physical or mental health conditions and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician or office staff and others outside of our office that are involved in you care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physicians' practice and any other required by law.

Treatment: We will use and disclosed your protected health information to provide, coordinate, or manage your healthcare and related services. This includes the coordination or management of your home health agency that provided care to you. Your protected health information may also be provided to a physician to whom you have been referred to, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for a hospital admission.

Healthcare Operation: We may use or disclose your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, the training of medical students, licensing, conducting, or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients in our office. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization as required by law. These situations include public health issues, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity, national security, workers' compensation, or inmates required uses or disclosures.

Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. At any time, you may revoke this authorization in writing, except to the extent that your physician or the physicians practice has to take action in reliance to the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your protected health information: however, under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in a reasonable anticipation of use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes a described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to the restrictions you request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted. You then have the right to use another healthcare professional.

You may have the right to have your physician amend your protected health information. If the request for amendment is denied, you have the right to file a statement of disagreement with us. We may prepare a rebuttal and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of any disclosures we have made of your protected health information. You have the right to request confidential communications from us by alternate means or location.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before August 5, 2013.

We are required by law to maintain the privacy of and provide individuals with notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with your physician in person or by phone.

Please initial and sign the NOTICE AND ACKNOWLEDGMENT form to verify that you have read and understand this document.

Financial Policy

Petoskey Family Medicine

1890 U.S. 131 South, Petoskey, MI 49770

It is the financial policy of Petoskey Family Medicine (PFM) to collect all co-pays, deductibles, and non-covered services at the time of service. We accept the following methods of payment: Cash, Personal Checks, Visa, MasterCard, American Express and Discover. There will be a **$35.00** charge for insufficient funds/returned checks.

If you have no insurance, payment is expected at the time of your visit unless other arrangements have been made prior to your appointment.

It is the PFM policy to charge **$50.00** per no-show appointment. Please call within 24 hours o cancel if you are unable to keep your scheduled appointment. This gives us time to contact another patient who may be waiting to see a provider.

Sample medications are a courtesy service to our patients.

If you are requesting copies of medical records, i.e.: Taking records to a winter address, for your personal files, etc., there will be a charge. The fee is based on the amount of records requested and will be disclosed before the records are copied.

We will charge for completion of all non-standard insurance forms, i.e.: Disability, AFLAC, Financial Institutions, etc. This fee will be based on the length of the forms and will be disclosed before the forms are completed.

We **DO NOT** charge for filling out handicap parking permits.

We welcome the opportunity to serve you and are always willing to discuss any aspect of our financial policy. Please contact our practice at (231) 487-6000.

PFM participates with the following insurance companies: Blue Cross Blue Shield, Blue Care Network, Priority Health, McLaren Health Advantage, Medicare, Tricare and Cofinity.

Please initial and sign the NOTICE AND ACKNOWLEDGEMENT form to verify that you have read and understand this document.

Petoskey Family Medicine

Medical History

Name: _____ Age: _____ Birthdate: _____

Marital Status: _____ Occupation: _____ Retired: Yes or No

Education: _____ Children: _____ Ages: _____

Illnesses: (for which you have been or are being treated)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Surgeries: (where and when)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Tobacco use: Current smoker Y N How many years: _____ Packs per day _____

Alcohol use: Y N Drinks per day: _____

Illicit drug use: Y N What kind: _____

Family history:	Age	Illnesses	Cause of death	Age of death
Mother:				
Father:				
Brother(s):				
Sister(s):				

Blood relatives with: Who?

Breast Cancer: Y N _____

Colon Cancer: Y N _____

Prostate Cancer: Y N _____

Diabetes: Y N _____

Stroke: Y N _____

Thyroid: Y N _____

Continue on other side ⟹

Current Medications: (Prescribed and Over the Counter) Dose Usage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Drug allergies: Y N Reaction

1. _____
2. _____
3. _____

Other allergies:

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

Immunizations: (include dates) Hep A: _____ Hep B series: _____ Tetanus: _____

Pneumovax: _____ Influenza: _____ TB skin test: Y N

For Women:

Number of pregnancies: _____ Number of live births: _____

Number of living children: _____ Number of abortions: _____

Number of miscarriages: _____ Age when periods began: _____

Days of Bleeding: _____ Days between cycles: _____

First day of last period: _____ Age of menopause: _____

Date of last PAP smear: _____ Where: _____

Date of last mammogram: _____ Where: _____

HIV testing: Y N Date: _____ Results: _____

Thank you!

Petoskey Family Medicine Intake For Annual Exam
Welcome! Please indicate if you are experiencing any of the following

General

- o Appetite loss
- o Chills
- o Dietary Changes
- o Fatigue
- o Fever
- o Medication Changes
- o Night Sweats
- o Tiredness
- o Weight Gain > 10 lbs.
- o Weight Loss > 10 Lbs.
- o Unable to Sleep Lying Flat
- o Shakiness

Skin

- o Change in Wart/Mole
- o Clamminess
- o Coarse Hair/Skin
- o Cracked Lips
- o Dryness
- o Hair Growth/ Loss
- o Hives
- o Itching
- o Nail Changes
- o New Lesions
- o Rash
- o Ulcer
- o Cold Skin

Neck

- o Neck Pain
- o Neck Stiffness
- o Neck Swelling
- o Swollen Glands

Respiratory

- o Cough
- o Decreased Exercise Tolerance
- o Dyspnea/ Short of Breath
- o Snoring
- o Sputum Production
- o Wheezing

Head/Ears/Eyes/Nose/Throat

- o Headache
- o Blurred Vision
- o Decreased Night Vision
- o Double Vision
- o Excessive Tearing
- o Eye Pain
- o Eye Redness
- o Glaucoma
- o Visual Disturbance/Loss
- o Wears Glasses/Contacts
- o Hearing Loss
- o Decreased Hearing
- o Ear Discharge
- o Earache/Pain
- o Ringing in Ears
- o Vertigo
- o Runny Nose
- o Nose Bleed
- o Frequent Colds
- o Nasal Congestion
- o Sneezing
- o Seasonal Allergies
- o Sleep Apnea
- o Sinus Pain
- o Rhinitis
- o Bleeding Gums
- o Voice Changes/Hoarse
- o Dry Mucous Membranes
- o Decreased Sense of Smell
- o Decreased Sense of Taste
- o Difficulty Chewing
- o Drooling

Breast

- o Breast Mass
- o Breast Pain
- o Breast Swelling
- o Nipple Discharge

Cardiovascular

- o Abnormal Blood Pressure
- o Chest Pain
- o Difficulty breathing lying down
- o Difficulty breathing on Exertion
- o Edema
- o Fainting/Blacking Out
- o Hypertension
- o Irregular Heartbeat
- o Leg Pain/Swelling
- o Night Cramps
- o Palpitations
- o Rapid Heart Rate
- o Slow Heart Rate
- o Swelling of Extremities

GastroIntestinal

- o Abdominal Mass
- o Abdominal Pain
- o Belching
- o Bloating
- o Bloody Stool
- o Change in Bowel Habits
- o Constipation
- o Diarrhea
- o Difficulty Swallowing
- o Food Intolerance
- o Gas
- o Hemorrhoids
- o Heartburn
- o Indigestion
- o Jaundice
- o Laxative Use
- o Nausea
- o Painful Swallowing
- o Pain with Bowel Movement
- o Rectal Bleeding
- o Vomiting

Continue to Page 2

Petoskey Family Medicine Intake For Annual Exam
Welcome! Please indicate if you are experiencing any of the following

Female Genitourinary

- o Absence of Menstruation
- o Blood In Urine
- o Change in Bladder Habits
- o Change in Urinary Stream
- o Difficulty Emptying Bladder
- o Discharge
- o Excessive Non-Menstrual Bleeding
- o Flank Pain
- o Frequency
- o Hesitancy
- o Incontinence
- o Menstrual Irregularities
- o Painful Intercourse
- o Painful Menstruation
- o Painful Urination
- o Pelvic pain
- o Stress Incontinence
- o Urgency
- o Vaginal Bleeding
- o Vaginal Discharge
- o Vaginal Dryness
- o Vaginal Itching/Burning
- o Excessive Urination at night
- o Urine Leakage

Male Genitourinary

- o Blood In Urine
- o Change in Bladder Habits
- o Change in Urinary Stream
- o Difficulty with Erection
- o Discharge
- o Flank Pain
- o Frequency
- o Hesitancy
- o Impotence
- o Incontinence
- o Painful Urination
- o Penile Lesions
- o Testicular Mass
- o Testicular Pain
- o Urethral Discharge
- o Urgency
- o Urinary Retention
- o Excessive Urination at Night
- o Urine Leakage

Musculoskeletal

- o Back Pain/Backache
- o Calf Pain/Cramps
- o Decrease Range of Motion
- o Joint Pain
- o Joint Redness
- o Joint Stiffness
- o Joint Swelling
- o Leg Cramps
- o Muscle Cramps
- o Muscle Pain
- o Muscle Weakness

Neurological

- o Attention Deficit/ Hyperactivity
- o Decreased Memory
- o Difficulty Speaking
- o Dizziness
- o Easily Distracted
- o Fainting
- o Headaches/Migraines
- o Incoordination
- o Loss of Consciousness
- o Numbness
- o Seizures
- o Syncope
- o Stroke
- o Tremor
- o Trouble Walking
- o Unusual Sensation
- o Unsteadiness/Falls
- o Weakness
- o Weakness In Extremities
- o Muscle Twitching
- o Tingling
- o Slow Reflex

Psychiatric

- o Anxiety
- o Change in Sleep Pattern
- o Depression
- o Disorientation
- o Early Awakening
- o Easily Irritated
- o Fearful
- o Frequent Crying
- o Fussiness/Moodiness
- o Hallucinations
- o Hypersomnia
- o Impaired Cognitive Function
- o Inability to Concentrate
- o Insomnia
- o Memory Loss
- o Mood changes
- o Nervousness
- o Panic Attack
- o Suicidal Ideation
- o Suicidal Planning
- o Trouble Falling Asleep
- o Withdrawn
- o Personality Changes

Endocrine

- o Appetite Changes
- o Cold Intolerance
- o Decreased Sweating
- o Excessive Sweating
- o Excessive Thirst
- o Hair Changes
- o Heat Intolerance
- o Libido Changes
- o Sexual Dysfunction
- o Thyroid Problems

Hematology

- o Abnormal Bleeding
- o Anemia
- o Blood Clots
- o Easy Bruising
- o Enlarged Lymph Nodes
- o Painful Lymph Nodes

Thank You!