



## PATIENT/FAMILY HISTORY

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date: \_\_\_\_\_

- 1) Under each family member, place a check in the box.
- 2) Place an asterisk ( \* ) by the cause of death for each family member, and age if known

Mother:    \_\_\_ Healthy \_\_\_ Age \_\_\_       \_\_\_ I am adopted: Unknown family history  
 Father:    \_\_\_ Healthy \_\_\_ Age \_\_\_

	Patient	Mother	Father	Sister	Brother	OTHER FAMILY MEMBERS
Name of Family Member						
<b>DIAGNOSIS</b>						
Alcoholism						
Asthma						
Blood Disease						
Bleeding Disorder						
Brain disease						
Cancer: lung						
Cancer: breast						
Cancer: colon						
Cancer:						
Cancer:						
CVA/ Stroke						
Depression						
Diabetes						
Emphysema						
Heart Disease						
Hyperlipidemia/Chol.						
Hypertension						
Kidney disease						
Liver Disease						
Mental Illness						
Migraines/ Headaches						
Obesity						
Parkinson's/tremors						
Seizures/Epilepsy						
Sickle Cell						
Sleep Apnea						
Vascular Disease						
History of smoking						
Misc./other						

**FAMILY HISTORY COMMENTS:** \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date: \_\_\_\_\_

<u>Medication/Dosage</u>	<u>How Often</u>	<u>For what problem</u>

<u>Medication Allergies and Reaction</u>	

<u>Past Medical History</u>		
<u>Operations/Procedures</u>	<u>Month/Year</u>	<u>Medical Facility</u>

<u>Diagnostics/Testing done in the last year</u>		
<u>Test/Procedure</u>	<u>Month/Year</u>	<u>Medical Facility</u>

<u>Hospital/Urgent Care/ER Visits</u>		
<u>Reason for Hospitalization</u>	<u>Month/Year</u>	<u>Medical Facility</u>

<u>Social History</u>		
<b>Currently Smoking:</b> Yes    No	<b>How many packs a day:</b> _____	
<b>Former Smoker:</b> Yes    No	<b>How many years have you smoked?</b> _____	
<b>Caffeine:</b> Yes    No	<b>Type:</b> Coffee, Tea, Soda	<b>Cups Daily:</b> _____
<b>Alcohol:</b> Yes    No	<b>Type:</b> Beer, Wine, Liquor, Variety	<b>Drinks Daily:</b> _____
<b>Pets:</b> Yes    No	<b>Type:</b> Dog, Cat, Bird, Reptile, Rodent, Other: _____	
<b>Occupational Exposure/Hazards:</b> _____		

<u>Preferred Pharmacies</u>		
<u>Name</u>	<u>City</u>	<u>Street</u>
1.		
2.		

***Pulmonary and Critical Care Associates***

*A Division of Michigan Multispecialty Physicians, P.C.*

5333 McAuley Drive, Suite 3111

Ypsilanti, MI 48197

(734) 712-7688

Fax: (734) 712-7056

William F. Patton, M.D.  
Paul S. Harkaway, M.D.  
Thomas R. Gravelyn, M.D.  
Gregory R. Neagos, M.D.  
Sheila C. Tsai, M.D.

Susan J. Gravelyn, M.D.  
Shelly J. Neitzel, M.D.  
Christine L. Curran, M.D.  
Kathleen M. Kerr, PA

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I (patient's name) \_\_\_\_\_ authorize my treating

Physician ( \_\_\_\_\_ ) from Pulmonary & Critical Care

Associates to release and discuss my medical information with the following person(s):

**NAME:**

**RELATIONSHIP:**

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**OR**

\_\_\_\_\_ **RELEASE INFORMATION TO PATIENT ONLY**

**Patient's Printed Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**ASSIGNMENT OF INSURANCE BENEFITS**

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO PULMONARY AND CRITICAL CARE ASSOCIATES FOR SERVICES RENDERED BY THIS PRACTICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I AUTHORIZE THIS PRACTICE TO RELEASE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY FOR PROCESSING MY MEDICAL CLAIMS FOR PAYMENT.

PATIENT'S PRINTED NAME: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

\*THIS FORM IS NOT TO BE USED FOR BILLING PURPOSES ONLY. THIS IS NOT TO BE IN PLACE OF RELEASE OF MEDICAL RECORD FORM.

**Receipt of Notice of Privacy Practices**

I received a copy of the Michigan Multispecialty Physicians, PC  
Notice of Privacy Practices on \_\_\_\_\_ (date).

Patient's Printed Name: \_\_\_\_\_

Patient's (or Rep) Signature: \_\_\_\_\_

**OFFICE USE ONLY**

PR      Other \_\_\_\_\_ MMP Signature \_\_\_\_\_

EFFECTIVE DATE OF THIS NOTICE: MARCH 1, 2003

**MICHIGAN MULTISPECIALTY PHYSICIANS, PC**  
**PULMONARY DIVISION**  
5333 MCAULEY DRIVE SUITE 3111  
YPSILANTI, MI 48197  
PHONE 734 712-7688 FAX 734 712-7056  
DIVISION CONTACT: LORI WURTZ

### **NOTICE OF PRIVACY PRACTICES**

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

Your medical information is personal and we are committed to protecting your privacy. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your medical information and what rights you have regarding information. If you have any questions, please contact the division contact shown above.

**We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that our practice has created or maintained and for any generated in the future. Our practice will post a copy of our current Notice in our offices in a visible location and you may request a copy of our most current Notice at any time.**

#### **HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION**

The following categories describe the ways in which we may use and disclose your medical information. We routinely use your medical information inside our office for these purposes without any special permission. For clarification, we have included some examples. Not every possibility 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.

**Treatment.** Our practice may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, ordering prescriptions, referring you to other medical professionals, or obtaining copies of information from other providers. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children or parents.

**Payment.** We may use and disclose your medical information in order to bill and collect payment for services. For example, we may provide your insurer with treatment information to certify eligibility. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for costs, such as family members.

**Health Care Operations.** Our practice may use and disclose your medical information to operate our business. Examples may include using your medical information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

**Appointment Reminders.** Our practice may use and disclose your medical information to contact you and remind you of an appointment.

**Treatment Options and Health-Related Benefits.** Our practice may use and disclose your medical information to inform you of potential treatment options or health-related benefits or services that may be of interest to you.

**Disclosures Required By Law.** Our practice will use and disclose your medical information when we are 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 births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

**Health Oversight Activities.** Our practice may disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, 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.

**Lawsuits and Similar Proceedings.** If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office. We also may disclose your information in response to a discovery request, subpoena, or other lawful process by another party involved, but only if we have tried to inform you of the request or to obtain an order protecting the information the party has requested.

**Law Enforcement and/or National Security.** We may disclose your medical information for law enforcement purposes. For example, we may provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened elsewhere. Further, we may disclose your medical information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

**Deceased Patients.** Our practice may release medical information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

**Research.** Under certain circumstances, we may use and disclose your medical information for health related 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.

**Serious Threats to Health or Safety.** Our practice may use and disclose your medical information to 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.

**Incidental Disclosures.** Our practice may disclose your medical information if it is an unavoidable byproduct of conducting business, including receiving services from cleaning personnel and those maintaining or repairing equipment.

**Business Associates.** Our practice may disclose your medical information to business associates who perform health care operations for us and who commit to respect the privacy of your health information.

Other uses and disclosures of your medical information not covered by this Notice will be made only with your written authorization. If you provide us such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

## **YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

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

**Confidential Communications.** You have the right to request that we communicate with you in a particular manner. For instance, you may ask that we contact you at home rather than work. To request a type of communication, you must make a written request to the division contact listed on page one of this notice. We will accommodate reasonable requests.

**Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your medical information for treatment (except in emergencies or when required by law), payment or health care operations. We are not required to agree to your request; if we do agree, we are bound by our agreement. You also have the right to request that we restrict our disclosure of your medical information to only certain individuals involved in your care. To request a restriction, you must make your request in writing to the division contact listed on page one.

**Inspection and Copies.** You have the right to see and copy your medical information. You must submit your request in writing to the division contact listed on page one. Our practice may charge a fee for the costs of copying and mailing your information. By law, our practice may deny your request to see and/or copy your information in certain limited circumstances, however, you may request a review of our denial. For information regarding such a review, contact the division contact listed on page one of this notice.

**Amendment.** If you feel that medical information we have about you is incorrect or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request and should be sent to the division contact listed on page one. We may deny your request if it is not in writing or does not include a reason. Further, we may deny your request if you ask us to amend information that is, in our opinion, accurate and complete, not part of the information kept by us, not part of the medical information which you would be permitted to see and copy, or if it was not created by us.

**List of Disclosures.** You have the right to request a list of disclosures our practice has made of your medical information for non-treatment, non-payment or non-operations purposes. Use of your medical information as part of the routine patient care in our practice is not required to be documented and, therefore, will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosures, you must submit your request in writing to the division contact listed on page one. All requests must state a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional lists may require payment.

**Right to a Paper Copy of This Notice.** You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, write to the division contact listed on page one of this notice or go to our website at [www.mmphealthcare.com](http://www.mmphealthcare.com).

**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, write to the division contact listed on page one. This office will not penalize you in any way for submitting a request.

# REVIEW OF SYSTEMS

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date: \_\_\_\_\_

WHY ARE YOU BEING SEEN TODAY? \_\_\_\_\_

Please check the following statements that are true to your condition today:

- |                                                |                                                              |                                                                   |
|------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Weight gain           | <input type="checkbox"/> Weight loss                         | <input type="checkbox"/> Fever                                    |
| <input type="checkbox"/> Night sweats          | <input type="checkbox"/> Fatigue                             |                                                                   |
| <input type="checkbox"/> Vision changes        | <input type="checkbox"/> Hearing loss                        | <input type="checkbox"/> Post nasal drip                          |
| <input type="checkbox"/> Nosebleeds            | <input type="checkbox"/> Nasal congestion                    |                                                                   |
| <input type="checkbox"/> Snoring               | <input type="checkbox"/> Bloody sputum                       | <input type="checkbox"/> Shortness of breath                      |
| <input type="checkbox"/> Wheezing              | <input type="checkbox"/> Cough                               |                                                                   |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Profuse sweating                    | <input type="checkbox"/> Difficulty breathing except when upright |
| <input type="checkbox"/> Palpitation           | <input type="checkbox"/> Fainting spells                     | <input type="checkbox"/> Shortness of breath when waking up       |
| <input type="checkbox"/> Blocked veins         | <input type="checkbox"/> Swelling                            |                                                                   |
| <input type="checkbox"/> Nausea                | <input type="checkbox"/> Reflux                              | <input type="checkbox"/> Bleeding                                 |
| <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Abdominal pain                      | <input type="checkbox"/> Anorexia                                 |
| <input type="checkbox"/> Difficulty swallowing |                                                              |                                                                   |
| <input type="checkbox"/> Blood in urine        | <input type="checkbox"/> Frequent night urination            |                                                                   |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Memory loss                         | <input type="checkbox"/> Seizures                                 |
| <input type="checkbox"/> Headache              |                                                              |                                                                   |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Hallucinations                      |                                                                   |
| <input type="checkbox"/> Acute Anemia          | <input type="checkbox"/> Decreased platelets                 |                                                                   |
| <input type="checkbox"/> Sexual dysfunction    | <input type="checkbox"/> History of oral contraceptive's     |                                                                   |
| <input type="checkbox"/> Heat intolerance      | <input type="checkbox"/> Cold intolerance                    | <input type="checkbox"/> Goiter                                   |
| <input type="checkbox"/> Tremors               |                                                              |                                                                   |
| <input type="checkbox"/> Rash                  | <input type="checkbox"/> Skin sores                          |                                                                   |
| <input type="checkbox"/> Joint pain            | <input type="checkbox"/> Muscle pain/spasms general weakness |                                                                   |

Comments