COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

CONSENT/PATIENT INFORMATION

PF02996 (2/11)

PATIENT I.D. _____

Patient Full Legal Name: _____ Photo ID: y/n _____

Date of Birth: _____ Soc Sec #: _____ Patient Sex: _____ Male _____ Female

Address: _____ Marital Status: S / M / D / W

City, State, Zip: _____ Ethnicity: _____

Telephone: _____ Preferred Language: _____

Cell Phone#:(_____) _____ Race: White / Black / Hispanic / Asian / Other

Email Address: _____

Contact Person Other than Home: _____ Telephone #: (_____) _____ - _____

Patient Employer: _____ Employer Telephone: _____

Employer Address: _____ Date of Retirement: _____

Student:Full Time: _____ Part Time: _____ Parent/Guardian: _____

Family Doctor: _____ ReferringDoctor: _____

Pharmacy _____ Location: _____

BILL TO:Self___Parent/Guardian___Work comp___Auto___Insured Name & Date of Birth _____

Primary Insurance: _____ Secondary Insurance: _____

Spouse Name: _____ Spouse Employer: _____

Spouse Date of Birth: _____ Employer Address: _____

Spouse Soc. Sec. #: _____ - _____ - _____ Date of Retirement: _____

AUTHORIZATION FOR MEDICAL INSURANCE BENEFITS

1) I assign payment to be made on my behalf to Covenant Healthcare.
2) I also authorize Covenant Healthcare to furnish information necessary for claims processing to any insurance carrier concerning my illness and treatments.
3) A universal claim form will be completed to help expedite insurance carrier payment.
4) I understand that all professional services will be charged to the patient for insurance other than our participating carriers.
5) Payment of the account is the patientís direct responsibility and I am responsible for any non-paid services.
6) Payment for services are due when rendered unless other arrangements have been made in advance with our billing staff.

Date _____ Patient Signature/Guardian _____

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PF08203 (R 12/04)

ACKNOWLEDGMENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT I.D.

I acknowledge, by signing below, that I have received a copy of the Covenant HealthCare **Notice of Privacy Practices**.

_____
Name

_____
Signature

Date:____/____/____

Covenant HealthCare Staff Use Only

Acknowledgment Received:_____/_____/_____

Reason Acknowledgment **was not** Received:

☐ I have previously received the Notice of Privacy Practices.

☐ Other, explain:

_____

_____

_____

Covenant HealthCare Staff _____
(Signature)

COVENANT HealthCare

MRN# _____

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PF00366 (R 7/08)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth _____
(Full Name of Patient - Print Clearly)

Address _____ Phone _____

City _____ State _____ Zip _____

1. I give permission for the use or disclosure of the protected health information (PHI) for the patient named above. This PHI will be used as described below:
2. The following person or business is allowed to disclose the PHI:
   Covenant HealthCare, _____
   _____
   _____
3. The type and amount of information to be used or disclosed is as follows: (If needed, include dates of service)

☐ Anesthesia Record and Operative Report	☐ Medication list
☐ List of allergies	☐ Immunization record
☐ Most recent history and physical	☐ Most recent discharge summary
☐ Laboratory results	☐ X-ray and imaging reports
☐ Consultation reports	☐ Entire record
☐ Other _____	

Dates of Service Requested: _____

4. I know that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and care for alcohol and drug abuse.
5. This information may be disclosed to and used by the following person or business:
   _____
   Address: _____
   for the purpose of: _____
6. I know I have the right to revoke this permission at any time. I know that to revoke this permission I must do so in writing and give my written revocation to the Health Information Management Department. I know the revocation will not apply to PHI that has already been disclosed in response to this authorization form. I know the revocation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy. If not revoked for other reasons, this authorization will end on the following date, event or condition: _____. If I do not state an expiration date, event or condition, this authorization will end within 60 days of the date signed.
7. I know that giving permission to disclose PHI is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I know I may inspect or copy the information to be used or disclosed, as provided by law in CFR 164.524. I know any disclosure of PHI carries with it the potential for an unauthorized re-disclosure and the PHI may not be protected by federal confidentiality rules. If I have questions about disclosure of my PHI, I can contact the Privacy Officer at (989) 583-4142 or Risk Management at (989) 583-4311.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness
(You must supply a legal document on appointment)

FOR COVENANT HEALTHCARE'S USE ONLY

IDENTIFICATION OF RECIPIENT OF RECORDS:

Driver's License: _____ State Issued: _____ Expiration Date: _____

Other Picture ID: _____ Covenant Employee Badge # _____

COVENANT HealthCare

Covenant Bay Primary Care
2919 E. Wilder Rd.
Suite 150
Bay City, MI 48706
Phone: (989) 671-5775 Fax: (989) 671-5767

MEDICATION MANAGEMENT AGREEMENT

PF08850 (R 1/13)

PATIENT I.D. _____

This Agreement between _____, (Patient) and _____, (Physician) is for the purpose of establishing agreement between Patient and Physician on clear conditions for the prescription and use of **pain controlling medications** prescribed by Physician for Patient. Physician and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a Physician/Patient relationship.

Patient agrees to and accepts the following conditions for the management of **pain medication** prescribed by Physician for Patient.

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.
- I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability has been evaluated or I have not used any medication for at least four days.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell or trade my medication prescribed by Physician. I understand it is against the laws to do so.
- I will safeguard my medication from loss or theft and agree that the consequences of my failure to do so is that I will be without my prescribed medication for a period of time.
- I agree to use _____ Pharmacy, located at _____, for all my pain medication. If I change my pharmacy for any reason, I agree to notify Physician at the time I receive prescription.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize Physician and my Pharmacy to cooperate fully with any city, state, or federal law enforcement agency, in the investigation of any possible misuse, sale or other diversion of my pain medication.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- I agree that refills of my medication will be given only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. I understand that I must allow 24-48 of regular office hours for prescriptions to be refilled.

Physician and Patient agree that this Agreement is essential to Physician's ability to treat Patient's pain effectively and that the failure of Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by Physician and the termination of the Patient/Physician relationship.

This Agreement is entered into on this _____ day of _____, 20 _____

_____ _____

Patient
(I acknowledge receipt of a copy of this Agreement on the date stated above)

Physician

_____

Witness

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Suite 150
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PATIENT CENTERED MEDICAL HOME (PCMH)
Patient/Provider Agreement

PFO8853 (R 4/15) PATIENT I.D.

Good communication between patients and physicians is the key to better outcomes. My staff and I are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

Our Responsibilities to You:

- **Respect you as an individual** - we will not make judgements based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.
- **Respect your privacy** - your medical information will not be shared with anyone else unless you give permission or as required by law.
- **Provide the best possible treatment and advice based on current medical evidence** - we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage.
- **Manage your health status** - including well person/preventative care as well as treatment for acute and chronic diseases.
- **Provide you timely access to care** - in our practice, as well as facilitate timely access to a specialist diagnosis services, and other care as needed.

What We Ask of You:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your doctor about any changes in your health and well-being
- Take your medicine as ordered and follow your doctor's advice - if you are unwilling or unable to do so, be honest with your doctor.
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor first with all problems, unless you have a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans

PLEASE NOTE: Our office is open 7:30 a.m. to 5:00 p.m. Monday through Thursday and 7:30 a.m. to 11:00 a.m. Friday. When the office is closed, we have an answering service that will connect either me or a covering physician to address medical issues, which cannot wait until regular office hours. It is important that you keep all scheduled appointments and notify us sufficiently in advance if you need to cancel or reschedule appointments.

I am a Covenant affiliated physician. Please attempt to call me before going to Med Express or to the emergency room unless you believe you have a serious problem requiring immediate medical attention.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

Patient	Patient or Representative Signature	Date

Physician/Representative Signature	Date