bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES

FOR

MEDICAL CLINIC OF NORTHVILLE

Ross Summer, M.D.
Cheryl Johnstone, M.D.
Amy Berke, M.D.
Mirella Ducu, M.D.

Revised 1/22/2020

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

Introduction

At Medical Clinic of Northville, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective September 23, 2013, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Medical Clinic of Northville, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Medical Clinic of Northville, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken. This includes the right restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service.

Our Responsibilities

Medical Clinic of Northville is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you of any breach of your unsecured Protected health Information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. Authorizations will be required for:

- Use and disclosures of psychotherapy notes,
- Use and disclosure of Protected Health Information for marketing purposes,
- Disclosures that constitute the sale of Protected Health Information,
- Any other use and disclosure not described in this Notice of Privacy Practices,

We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, at (248) 349-1900.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the

MEDICAL CLINIC OF NORTHVILLE

Patient Information

First Name:	M.I.	Last Name:		Today's Date:
Street Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security Number:	
Date of Birth:	Age:	Sex(Circle One) M F	Spouse's Name:	Work Phone:
Employer:		Occupation (indicate if student):		
Street Address:		City:	State:	Zip Code:

Responsible Party (if other than patient)

First Name:	M.I.	Last Name:		Date of Birth:
Street Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Social Security Number:	Employer:	
Employer Street Address:		City:	State:	Zip Code:

Miscellaneous Information

Referred By:

Emergency contact not living with you: Phone Number:

Would you like information on a living will?

____ Yes ____ No

MEDICAL CLINIC OF NORTHVILLE
PEDIATRIC HISTORY

Child's Name: _____ Age Today: _____ Date: _____

Previous Physician: _____ Referred By: _____

BIRTH HISTORY

Date of Birth: _____ Hospital: _____ Birthweight: _____ Length: _____

Prenatal Problems: ___ No ___ Yes If Yes, please list: _____

_____

Full-Term or Premature: _____

Type of Delivery: ___ Vaginal ___ C-Section

Problems after birth or during first week (0=None):

Breathing Problems _____

Convulsions _____

Jaundice _____ If yes, was treatment needed? _____

Feeding Problems _____

Other _____

_____

Breast Fed (how long?): _____

Bottle Fed (type(s) of formula): _____

FAMILY

Mother's Name: _____ Age: _____ Health: _____ Occupation: _____

Father's Name: _____ Age: _____ Health: _____ Occupation: _____

Brother's Name: _____ Age: _____ Health: _____

Brother's Name: _____ Age: _____ Health: _____

Brother's Name: _____ Age: _____ Health: _____

Sister's Name: _____ Age: _____ Health: _____

Sister's Name: _____ Age: _____ Health: _____

Sister's Name: _____ Age: _____ Health: _____

Parent's Marital Status: ___ Married ___ Divorced ___ Never Married ___ Separated

Residence: City Name _____ ___ House ___ Apartment/Condo ___ Mobile Home

School Name: _____ Grade: _____ Grades: ___ Above Avg. ___ Avg. ___ Poor

Preschoolers: In Daycare ___ Yes ___ No If yes, # of days per week _____

Name of sitter/school: _____

IMMUNIZATIONS - List Date(s):

D.P.T./D.T./t.d.	_____	_____	_____	_____	_____
Oral Polio	_____	_____	_____	_____	_____
M.M.R.	_____	_____	_____	_____	_____
H.I.B.	_____	_____	_____	_____	_____
TB tine	_____	_____	_____	_____	_____
Hemoglobin	_____	_____	_____	_____	_____
Urinalysis	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Allergies: _____ Current Medications: _____

Please Turn Over and Complete the Back Side

PAST HISTORY

Please check yes for no to indicate whether your child has had any of the following diseases.

	Yes	No		Yes	No
Roseola (Baby Measles)	____	____	Mumps	____	____
Rubella (German or 3-day measles)	____	____	Chickenpox	____	____
Rubeola (Hard or 7-day measles)	____	____	Scarlet Fever	____	____
Mononucleosis	____	____	Strep Throat	____	____
Pneumonia	____	____	Ear Infection	____	____
Bladder Infection	____	____	Asthma or "Wheezing"	____	____
Heart Murmur	____	____	Seizures	____	____
Diabetes	____	____	Hives/Skin Problems	____	____
Fainting	____	____	Bed-wetting	____	____
Bowel Problems	____	____	Behavior Problems	____	____
Fracture	____	____	Sutures	____	____
Menstrual Problems	____	____	Age of 1st Period	____	

Other _____

Previous hospitalizations/ER visits (give name of hospital, type of problem, and childs age – if none, please write "none")

_____

_____

FAMILY HISTORY

Please indicate any of the following medical problems within your child's family history:

M = Mother F = Father S/B = Sister or Brother
GP = Grandparent A/U = Aunt/Uncle GPP = Great Grandparent

	M	F	S/B	GP	A/U	GGP
Tuberculosis (T.B.)						
Allergy/Asthma						
Heart Attack before Age 40						
Hypoglycemia (low blood sugar)						
Convulsions						
Heart Disorder						
Cancer						
Hypertension (high blood pressure)						
Arthritis						
Kidney/Bladder Disorder						
Stroke						
Bleeding Disorder						
Muscle Disorder						
Other						

History of birth defect: _____

History of S.I.D.S.: _____

_____ _____

Signature of Parent/Guardian **Date**

Medical Clinic of Northville

308 S. Main Street
Northville, MI 48167

Today's Visit

Date: _____

Main reason for today's visit:

_____

_____

_____

Check all that apply:

- ☐ Review labs/or test results
- ☐ I have prescriptions that need to be refilled
- ☐ I need a school or work excuse
- ☐ I need a referral for my insurance company
- ☐ I need the attached forms filled out

Patient's Name: _____

Patient's Date of Birth: ____/___/_____

Any change in personal health history since last visit?

_____

_____

Any change in family health history since last visit?

_____

_____

Any new medication prescribed by another physician?

_____

_____

MEDICAL CLINIC OF NORTHVILLE
Privacy Policy Acknowledgement

I have been given a copy of the Notice of Privacy Policy for Medical Clinic of Northville. This is to certify that I have read and understand these policies.

Signature	Print Name	Date

I understand the contents of the Notice of Privacy Policy, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Messages regarding appointments with this office may be left on my home answering machine or with persons answering my home phone: _____ No _____ Yes

Messages regarding test results may be given someone other than myself:

___ No ___ Yes If yes, whom may we speak to: _____

I request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply. If not signed by patient, please indicate relationship to patient (i.e. spouse or parent)

Signature	Print Name	Date

Relationship	Witnessed By

Internal Use Only:

If patient or patient's representative refused to sign acknowledgement of receipt of Notice of Privacy Policy, please document the date and time the Notice was presented to the patient and sign below.

Signature	Date

GENERAL CONSENT TO TREATMENT

PATIENT NAME: _____

1. REQUEST AND CONSENT TO AMBULATORY SERVICES.

By signing this form, I am requesting and consenting to the 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 these 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 Medical Clinic personnel doing the things they would normally do in caring for a patient, and as instructed by the physician. I understand that the Medical Clinic may perform non-diagnostic tests on the patient's blood, urine and other bodily fluids/tissues that were drawn for diagnostic purposes, and the Medical Clinic may dispose of these specimens as it chooses. I understand that General Consent to Treatment (entire form) will remain in effect until such time as I cancel (revoke) it in writing.

2. NO GUARANTEES.

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

3. HUMAN IMMUNODEFICIENCY VIRIS (HIV) TESTING.

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

4. RELEASE OF INFORMATION.

I authorize the Medical Clinic to release information from the patient's medical record, including:

a) 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".

b) substance abuse treatment information protected by 42 Code of Federal Regulations Part 2.

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

1) any, third party payer or insurance company (including Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workel"s' disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans) which are responsible in whole or in part for paying my Medical Center bill so that the Medical Center may be paid for its services; and/or
2) any health care facility or physician to which I am referred or transferred for continuity of care; and/or
3) any independent auditors or reviewers retained by any third party payer, private health insurer or any employer providing health insurance benefits to me so that these independent auditors can analyze Medical Clinic charges; and/or
4) any party retained by Medical Clinic to provide accounting, billing or collection services to Medical Clinic and parties to whom I may be referred to assist me in obtaining third party reimbursement for treatment, services and procedures rendered to me.

This release authorization shall be effective only so long as it is necessary to accomplish the purpose for which it is given. In regards to substance abuse information (if any), this consent may be revoked at any earlier time unless the Medical Clinic has already released information in reliance upon it.

5. PAYMENT PROVISIONS

NOTE: The term "health care benefits" in the following paragraphs means Medicate, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurance benefits, automobile no-fault benefits, workers' disability compensation benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

a) I understand that, except in limited circumstances, separate billings will be issued for services of the Health Center and services of physicians, and that neither charges are included in the billings of the other.
b) I request payment on the patient's behalf of all health care benefits for services provided by the Health Center and by physicians for whom the Health Center is authorized to bill.
c) I assign and transfer to the Health Center all health care benefits applicable to the patient's care, including those health care benefits listed on the first page of my medical record. I authorize and direct that all such health care benefits be paid directly to the Health Center.
d) I agree personally to pay for any Health Center or physician charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurance amounts.

I have read and understand this form, and consent to it. If the signer is not the patient, the signer certifies that he/she is the patient's legally authorized representative.

_____ _____

Signature of Patient or Patient Representative Date

MEDICAL CLINIC of NORTHVILLE

308 S. Main Street
Northville, MI 48167

To help us plan for advertising, please let us know how you were referred to our facility. Your help is greatly appreciated!

Your city of residence: _____
(This is used only to help us plan where to advertise - it is not shared with anyone)

You were referred to our practice by (please check all that apply):

[ ] Family Member

[ ] Friend/Co-Worker/Neighbor

[ ] Yellow Pages (internet)

[ ] Yellow Pages (phone book)

[ ] Hometown Directory

[ ] Insurance Directory (internet)

[ ] Insurance Directory (paper or book listing)

[ ] Internet (other than yellow pages or insurance directory)

[ ] Printed Media (Newspaper/Flyer)

[ ] Professional (Physician/Dentist/Lawyer/Etc.)

[ ] Pharmacy

[ ] Drive By

[ ] You were a previous patient

[ ] Other_____

Thank You!
The Staff at Medical Clinic of Northville

Medical Clinic of Northville

Recommendations

Our clinic is in the process of enhancing our current organization of your care. Please help us improve the quality of your medical care by providing us with updated information, as appropriate. We will need to request these records from the appropriate source, so please also indicate where you had the screening done.

If you do not know the exact date, please give us an **ESTIMATE of when you believe it was completed

	Date	Location/Provider where completed
For all patients		
Tetanus Vaccine	_____	_____
Influenza Vaccine	_____	_____
For all Females		
Mammogram	_____	_____
PAP smear	_____	_____
For ages 50 and older		
Colonoscopy *or* stool occult *or* sigmoidoscopy (please circle which one)	_____	_____
Shingles Vaccine	_____	_____
Pneumonia Vaccine	_____	_____
For Diabetics		
Diabetic Eye Exam	_____	_____
Foot exam	_____	_____

If you have records at home, bring those at your next appointment to complete this form

Printed Name _____ DOB_____

Signature _____ Date _____

Ethnicity _____ Preferred Language _____ Defer Response_____

12/5/14

MEDICAL
CLINIC
OF
NORTHVILLE

Ross A. Summers, M.D.
Cheryl A. Johnstone, M.D.
Amy L. Berke, M.D.

Patient Portal Access

Patient Name:_____ DOB:_____

Our office is creating a way to directly connect you to your medical record through the internet. However, we must send you an invitation to your email to join this network.
For security measures, in the email you receive, we also must have you answer a security question to allow you to begin having access.

To connect you to our new patient portal and provide you with direct access to lab results, please provide us with your email and **ONE** of the following answers.

Email:_____

Answer **ONE** of the following questions:

What are the last four digits of your social security number?_____
What is the year of your father's birth?_____
What is the year of your mother's birth?_____

(office use only)

Email and password entered into **Patient Portal** by:_____

Email entered into **Powerchart** by:_____

308 S. Main Street
Northville, MI 48167

(248) 349-1900
fax (248) 349-3195

MEDICAL CLINIC OF NORTHVILLE

Ross A. Summers, M.D.
Cheryl A. Johnstone, M.D.
Amy L. Berke, M.D.

NORMAL, REPEAT & CRITICAL VALUES

Results of critical value are called to the attention of the ordering physician as soon as possible. Critical values are reported to the ordering physician during normal office hours. All such calls are to be documented.

WAIVED TESTING

TEST	NORMAL	REPEAT	CRITICAL	UNITS
Blood Glucose (Fasting)	74-106	≥ 200	≥ 200	mg/dL
Blood Glucose (Non-Fasting)	70-140	≥ 200	≥ 300	mg/dL
Urine hCG (Non-pregnant)	Negative	NONE	NONE	NONE
Urine hCG (Pregnant)	Positive	NONE	NONE	NONE
URINALYSIS DIPSTICK				
Leukocytes	Negative	NONE	NONE	NONE
Nitrate	Negative	NONE	NONE	NONE
Urobilinogen (Male)	≤ 2	NONE	NONE	EU
Urobilinogen (Female)	≤ 1	NONE	NONE	EU
Protein	0--20	NONE	NONE	mg/dL
pH	5.0 - 8.0	NONE	NONE	NONE
Blood	Negative	NONE	NONE	NONE
Specific Gravity	1.003-1.029	NONE	NONE	NONE
Ketones	Negative	NONE	NONE	NONE
Bi lirubin	Negative	NONE	NONE	NONE
Glucose	≤ 30	NONE	NONE	mg/dL
Mononucleosis	Negative	NONE	NONE	NONE
Influenza A & B	Negative	NONE	NONE	NONE
Strep A Screen	Negative	NONE	NONE	NONE
Hemoccult	Negative	NONE	NONE	NONE
ESR (Sed Rate) (Male >50)	≤ 20	NONE	NONE	mm/hr
ESR (Sed Rate) (Male <50)	≤ 15	NONE	NONE	mm/hr
ESR (Sed Rate) (Female >50)	≤ 30	NONE	NONE	mm/hr
ESR (Sed Rate) (Female <50)	≤ 20	NONE	NONE	mm/hr
ESR (Sed Rate) (Children)	≤ 13	NONE	NONE	mm/hr
ESR (Sed Rate) (Newborn)	≤ 2	NONE	NONE	mm/hr

HEMATOLOGY

TEST	NORMAL	REPEAT	CRITICAL	UNITS
WBC	4.1 - 10.9	< 3.5 or > 13.0	< 2.5 or > 30.0	K/uL
HGB	12 - 18	< 10 or > 18	< 8 or > 18	g/dL
Platlet	140 - 440	< 100 or > 500	< 50 or > 999	K/uL
RBC	4.2 - 6.3	< 3.0 or > 7.0	None	M/uL
HCT	37 - 51	< 35 or > 55	None	%

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