Robert S. Peterson Building
45580 Woodward Ave
Pontiac, MI 48341
248-309-3752-Phone
248-309-3835-Fax
www.gbchc.org

**PATIENT APPLICATION CHECKLIST**

In order to become a patient at the Dr. Gary Burnstein Community Health Clinic, please submit the documents listed below in person. Our regular business hours are as follows:

Monday- Friday 9am to 4pm

☐ Income of or less than $33,975 last year for yourself and $11,800 additional per family member. (Example: $33,975 or less for yourself, if you have a child or spouse add $11,800 + $33,975= $45,775).

☐ Letter of Denial from Medicaid

☐ Supply Federal Income Tax Return Form, the form you need is called a 1040 for prior tax year. If you need help, please ask the front desk.

☐ Valid Photo ID/ Driver's License/ State ID /Green Card (ID must have a Michigan address).

☐ You must **re-qualify** each year. Failure to do so will result in your dismissal from the clinic.

All our services are free to qualified individuals. If you receive services using falsified information you may be billed for the cost of all the services you have received and discharged from our care.

We look forward to assisting you!
GBCHC Staff

Revised June 2022

# Patient Consent Contract

Authorization for Treatment

***PLEASE READ CAREFULLY –THIS IS A CONTRACT***

I consent to receiving services at Gary Burnstein Community Health Clinic (GBCHC). This treatment may include assessment, routine diagnostic procedures, medications, dental care and appropriate medical treatment as the attending Physician/Nurse Practitioner/Physician's Assistant considers necessary for my care. I acknowledge that no guarantees have been made to me as to the result of examination or treatment at this clinic.

I understand that the services I receive at GBCHC, or as a result of a referral from GBCHC, are being provided by health care practitioners and lay volunteers who are not receiving money and will also not be requested from any source. I understand, as provided by Federal and Michigan State law, that these volunteers are not liable for lawsuits as a result of acts or oversight. With the exception of acts amounting to failure, willful and cruel behavior, or intentions to injure me.

Any verbally abusive or threatening behavior to the clinic staff is grounds for dismissal of clinic services.

In the event that any agent of the GBCHC is exposed in any way with my bodily fluids, blood samples will be drawn from both parties to test for infectious diseases.

In the event that a patient must cancel an appointment, **we request that all cancelations occur 48 hours prior to your appointment.** I understand that three "**NO SHOW**" visits are grounds for ending of all clinic services.

**For medication refills**: Please call 2 weeks before you run out of your medication(s) to ensure that your health care is provided without interruption.

**By signing below, I state that I have read and agree with the terms of the contract above.**

| | |
|---|---|
| ________________________________ | ________________________________ |
| **SIGNATURE OF PATIENT/RESPONSIBLE PARTY** | **PATIENT NAME (PRINTED)** |
| ________________________________ | ________________________________ |
| **SIGNATURE OF WITNESS** | **DATE** |

# Patient Registration Form

_______________________________________ __________ __________ __________ ________
Last Name MI First Name Date of Birth SSN Race Religion

______________________________ ________________ _______ _______
Street Address City State Zip

___________________________ (_______) _______- _______ (_______)________-________ (_______)________-________
Email Home Phone # Cell Phone # Alternate Phone #

________________________________ Number of ER visits within the last 12 months: __________
Preferred Language

| Employment Status: | Medical Coverage: | Disabled: | Referred By: |
|---|---|---|---|
| ☐ Full Time<br>☐ Retired<br>☐ Part TIme<br>☐ Self-Employed<br>☐ Unemployed<br><br>Income:<br><br>$______________ yearly<br>(annual)<br><br>Number of people living in household is: __________ | Yes or No<br>If yes please specify: __________________<br>__________________________________<br>__________________________________<br>__________________________________<br>__________________________________ | ☐ Yes<br>☐ No<br><br>Military Status:<br>☐ Active Duty<br>☐ Veteran<br>☐ Retired<br>☐ None<br><br>Homeless:<br>☐ Yes<br>☐ No | ☐ Hope Center<br>☐ Other Shelter<br>☐ MPRI<br>☐ Online<br>☐ 211<br>☐ Family/Friend<br>☐ Hospital/Medical Facility:<br>__________________<br><br>Other:_____________ |

**Former Medical Provider:**
**Current Medical provider**: _______________________________________________________________________
Physician Name Phone Number Facility/Medical Center

**Former Dental Provider:**
**Current Dental Provider**: _______________________________________________________________________
Physician Name Phone Number Facility/Medical Center

## Emergency Contact:

1st ______________________________________________________________________
First/Last Name Relation to patient Phone Number

2nd ______________________________________________________________________
First/Last Name Relation to patient Phone Number

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**By signing below, I state that the above information is true to the best of my knowledge. I understand additional documents may be needed. I agree to allow GBCHC to release information to appropriate third parties for care received at the clinic. I also understand that my information will only be given to the responsible party and individuals which I have written consent.**

Patient Signature: ______________________________________________ Date: _________________

Patient Name: _________________________ Date of Birth: _____/______/_____

# Disclose Protected Health Information (Optional)

I authorize The Dr. Gary Burnstein Community Health Clinic to share all of my health information with the selected choice below:

☐ Myself Only ☐ Individual(s) I have listed

| Individuals Information: | | **Power of Attorney** (A person who can make health decisions for you.) |
|---|---|---|
| 1.) Name: | Address, City, Zip: | Circle one: Yes or No<br><br>Phone Number: |
| 2.) Name: | Address, City, Zip: | Circle one: Yes or No<br><br>Phone Number: |
| 3.) Name: | Address, City, Zip: | Circle one: Yes or No<br><br>Phone Number: |

**I understand that by signing this form I authorize the Dr. Gary Burnstein Community Health Clinic to discuss medical information regarding my health services and treatment at GBCHC, any test results, diagnoses and medical findings as well as substance, mental, and behavioral health disorders with persons listed above.**

| Signature of Patient or Legal Representative: | Date: / / |
|---|---|
| Printed Name of Patient or Legal Representative: | Date: / / |
| Legal Representative's Relationship to Patient | |

Revised May 2021

**DENTAL ONLY**

# Dental ■ Patient Medical History Form

Patient Name: ______________________________ Date of Birth: ____________ Date: ____________

**Please answer these questions as best you can. Please check the answer that is right for you, "Yes" or "No".**

## Medical:

| | | |
|---|---|---|
| Has there been a change to your health within the past year? Yes ☐ No ☐ | Name of Physician:<br>Phone number:<br>Date of last medical visit: | Have you had surgery, x-ray treatment, or chemotherapy for a tumor or other condition? Yes ☐ No ☐ |
| Are you under the care of a physician or receiving ongoing medical care? Yes ☐ No ☐ | Are you pregnant? Yes ☐ No ☐<br>Due date:<br>Do you breastfeed? Yes ☐ No ☐ | Have you ever been told you need to be pre-medicated prior to dental treatment? Yes ☐ No ☐ |

## Medical Information:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart attack<br>Yes ☐ No ☐ | High blood pressure<br>Yes ☐ No ☐ | Artificial joint<br>Yes ☐ No ☐ | Artificial heart valve<br>Yes ☐ No ☐ | Diabetes<br>Yes ☐ No ☐ | Asthma<br>Yes ☐ No ☐ | Emphysema<br>Yes ☐ No ☐ | Stomach issues<br>Yes ☐ No ☐ |
| Depression, Anxiety<br>Yes ☐ No ☐ | Arthritis, Back pain<br>Yes ☐ No ☐ | Hepatitis A, B, or C<br>Yes ☐ No ☐ | Seizures<br>Yes ☐ No ☐ | Stroke<br>Yes ☐ No ☐ | Headache<br>Yes ☐ No ☐ | Bleeding Disorder<br>Yes ☐ No ☐ | HIV/AIDS<br>Yes ☐ No ☐ |

## Dental:

| | | |
|---|---|---|
| Are you having any discomfort at this time? Yes ☐ No ☐ | Date of last dental visit:<br>Does dental work make you nervous?<br>Yes ☐ No ☐ | How often do you brush your teeth?:<br>How often do you floss your teeth?: |
| Have you ever had serious trouble with previous dental work? Yes ☐ No ☐ | Have you ever had any abnormal bleeding associated with previous extractions, surgery, trauma? Yes ☐ No ☐ | Do you use tobacco? Yes ☐ No ☐<br>What kind: How much:<br>Do you use alcohol? Yes ☐ No ☐<br>What kind: How much: |

**Medications:** Are you taking any prescription or over-the-counter medications? Yes ☐ No ☐

**Please list all prescription and non-prescription medications dosage, how often taken, and reason: (attach a separate sheet if more space is needed).**

| | |
|---|---|
| 1.) | 3.) |
| 2.) | 4.) |

**Allergies: Yes** ☐ **No** ☐ If so, please list allergies and what reactions occur?

| Allergy: | Reaction: |
|---|---|
| 1.) | |
| 2.) | |

I understand that, to the best of my knowledge, all of the answers are true and correct. If I ever have any change in my health or medications, I will inform The Gary Burnstein Community Health Clinic. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent or legal guardian) to the GBCHC**. We set aside time for you. If you're running late, please call us as soon as possible. If you miss an appointment, you may have to wait for another opening, could be 6 months or more. These rules are firm so that we can serve everyone in need of care in a timely manner.**

**Signature of Patient or Legal Guardian** **Print** **Date**

Revised July 2021

gary burnstein
community health clinic

Robert S. Peterson Bldg.
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# Dental Attendance Policy

**Show up on time (10 minutes before appointment)**

You will receive dental care at no cost and follow up appointments as needed. (initial) ________

**Patient's responsibility**

Changes or cancellations to appointments must be made at least 48hours' before <u>or</u> you will be rescheduled at the clinics convenience, which could be 6 months or more. (initial)________

**No Call/ No Show:**

You may be unable to receive services for up to 12 months. (initial) ________

I__________________________ (name), have read and accept the above attendance policy for the Dr. Gary Burnstein Community Health Clinic- Dental Clinic.

**<u>Failure to confirm appointment will result in loss of scheduled appointment</u>.**

Signature: __________________________ Date: _____________________

Revised July 2021

# INDIVIDUAL AUTHORIZATION FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date: ____________________

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information may be used or disclosed. Please read the information below carefully before signing this form.

## USES AND DISCLOSURES COVERED BY THIS AUTHORIZATION

As a **Gary Burnstein Community Health Clinic (GBCHC)** patient some of your health information is collected and maintained by this clinic. The clinic is required by law to maintain your privacy and the security of your health information and to provide you with this Notice of Privacy Practices. This Notice describes how your health information may be used and shared and explains your privacy rights. The clinic is required to follow the terms of this Notice. We may, however, change our privacy practices and the terms of this Notice in the future, and those changes may affect all health information maintained by the clinic. If our privacy practices change, you will be mailed a new Notice.

**PERMITTED USES AND SHARING OF YOUR HEALTH INFORMATION**:

**Treatment:** We will use and share your health information to ensure you are provided medical treatment and services. For example, GBCHC may share your health information with a doctor or hospital that is giving your health care.

**Health Care Operations:** We will use and share your health information for clinic operations necessary to make sure our clients receive quality care. For example, GBCHC may share your health information with an outside contractor to review hospital and doctors' records to assess the care you received.

**Future Communications:** We may use your health information to mail you information on health care programs and health care choices.

**Legal Requirements:** We will share health information about you when required to do so by federal or state law.

**To Avoid Harm:** We may use or share your health information to prevent serious threats to your health and safety or the health and safety of others.

**Research:** Under certain circumstances, we may share your health information for research purposes. All research projects must be approved, and the project must keep your information confidential.

**Public Health:** We may share your health information with public health agencies to prevent or control the spread of diseases.

**Health Oversight Activities:** We may share your health information to a health oversight agency for activities authorized by law. These activities may include, for example, audits, investigations, and inspections.

**Lawsuits and Disputes:** We may share your health information in response to a valid judicial or administrative order.

**Coroners, Medical Examiners and Funeral Directors:** Consistent with applicable law, we may share your health information to a coroner, medical examiner, or funeral director, so that they may carry out their duties. Your health information may also be shared to ensure organ and tissue donation.

**Workers Compensation:** We may share your health information with programs that give benefits for work-related injuries or illness.

**National Security and Intelligence Activities:** We may share your health information to authorized federal officials for activities related to national security and special investigations.
**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may share your health information to the correctional institution or law enforcement official for the purposes of health care or safety.

**YOUR HEALTH INFORMATION RIGHTS:**

**Right to See and Get a Copy of Your Health Information:** You may see and get a copy of your health information and billing records by making a written request to Gary Burnstein Community Health Clinic at the address provided within this form. We can only provide those records that were created for or on behalf of GBCHC. You may not see or get a copy of any psychotherapy notes or information prepared solely for use in a civil, criminal, or administrative legal action.
**Right to Request that We Correct Your Health Information:** If you feel that the health information we have provided to you is incorrect or incomplete, you may ask us to amend the information by making a written request to GBCHC Medical Director. In certain cases, the clinic may deny your request to amend your information.
**Right to a List of Disclosures Made of Your Health Information:** You have the right to a list of those instances in which we have shared your health information, other than for treatment, payment, and health care operations, or when you specifically authorized the clinic to share your information. Your request must be in writing to the clinic's Medical Director.
**Right to Request that Your Health Information be Communicated in a Confidential Manner:** You may request, in writing to the GBCHC's Medical Director that your health information be provided in a confidential manner, such as sending mail to an address other than your home. The clinic will honor reasonable requests.
**Right to Request that We Not Use or Share Your Health Information:** You have the right to request that we not use or share your health information for treatment, payment, or health care operations, or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. Your request must be in writing to the Medical Director, and we will consider your request, but we are not legally required to accept it.
**Right to a Copy of the Notice:** You may ask for a copy of this Notice anytime.

## When will this authorization expire?

[This authorization will expire after 10 years or if changes are made and the patient signs a new form.]

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

You have a right to refuse to sign this authorization. Your healthcare and your healthcare benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the clinic has already acted based upon your authorization. To revoke this authorization, please write to:
GBCHC 45580 Woodward Ave, Pontiac, MI 48341

## SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted the above.

________________________________________
Signature of Patient or Personal Representative

________________________________________
Print Name of Patient or Personal Representative

__________________
Date

________________________________________
Description of Personal Representative's Authority

## CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address: ______________________________

Telephone: ____________________ (daytime)

____________________ (evening)

Email Address (optional): __________________________________

THE PATIENT OR THEIR PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.