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

PATIENT APPLICATION CHECKLIST

In order to become a patient at the Gary Burnstein Community Health Clinic, please complete the enclosed documents in full, and bring them to the clinic 9am-4pm Monday, Wednesday, or Thursday.

- ☐ **A) Federal Income Tax Form 1040 for prior year.**

  OR

  B) Proof of Non-Filing Status Form from the IRS for last year

  (This can be obtained by calling the IRS at 800-829-1040 if you had no income and/or you have not filed a 1040 Tax Return. Ask them for the Proof of Non-filing Status. If you need help please ask the front desk.)
- ☐ **Signed Patient Consent Contract**
- ☐ **Completed Patient History Form**
- ☐ **Completed Registration Form**
- ☐ **Completed HIPAA Authorization Form**
- ☐ **Medicaid Denial Letter**
- ☐ **Valid Photo ID/Driver's License or State ID**

We look forward to assisting you!
GBCHC Staff

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

The Dr. Gary Burnstein Community Health Clinic is a nonprofit 501©(3). We are self funded. We bill no entity for services provided, all our services are free to qualified individuals. **If you obtain services using falsified information you will be held liable for cost of all services you have received and discharged from our care.**

gb gary burnstein community health clinic

Patient Consent Contract

Authorization for Medical 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, and appropriate medical treatment as the attending Physician/Nurse Practitioner/Physician's Assistant considers necessary for my care. I understand the practice of medicine is not an exact science, and 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 compensation and compensation will not be requested from any source. I understand, as provided by Federal and Michigan State law, that these volunteers are not liable for civil damages as a result of acts or omissions which may occur in providing services to me, except acts or omissions amounting to gross negligence or willful and wanton misconduct or were intended to injure me.

I understand that any verbally abusive or threatening behavior to the clinic staff is grounds for the termination of clinic services.

I understand that clinic resources are limited and valuable. By not cancelling appointments I am unable to keep, I am taking away an appointment from someone else. I understand that three "**NO SHOW"** visits are grounds for termination of all clinic services. ***All cancellations must be made within 24 hours of appointment time.***

To make sure that your health care is provided for in a timely manner, we need to make sure that **ALL REQUESTS FOR REFILLS** of prescriptions must be made by **MONDAY** of the week that they are due to expire. Do not call in a refill request if you are scheduled to see the Doctor.

My signature below constitutes my acknowledgement that I understand this request for consent and that I agree to its contents.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **PATIENT NAME (PRINTED)**

_____ _____

SIGNATURE OF WITNESS **DATE**

gary burnstein community health clinic

Patient History

Patient Name: _____ **Gender: Male ☐ Female ☐ Date:** _____

Birthdate: _____ **Age:** _____ **# of ER visits in the past 12 months:** _____

Allergies: ☐ **No/Unknown** ☐ **Penicillin** ☐ **Sulpha** ☐ **Codeine** ☐ **Iodine** ☐ **Bee Stings** ☐ **Gluten** ☐ **Other** _____

Symptoms: Please ✓ symptoms you currently have or have had in the past year

General		Gastrointestinal		Eye, Ear, Nose, Throat	
☐ Chills	☐ Headache	☐ Appetite Poor	☐ Hemorrhoids	☐ Bleeding Gums	☐ Hoarseness
☐ Depression	☐ Loss of Sleep	☐ Bloating	☐ Indigestion	☐ Blurred Vision	☐ Loss of Hearing
☐ Dizziness	☐ Loss of Weight	☐ Bowel Changes	☐ Nausea	☐ Crossed Eyes	☐ Nosebleeds
☐ Fainting	☐ Nervousness	☐ Constipation	☐ Rectal Bleeding	☐ Difficulty Swallowing	☐ Persistent Cough
☐ Fever	☐ Numbness	☐ Diarrhea	☐ Stomach Pain	☐ Double Vision	☐ Ringing in Ears
☐ Forgetfulness	☐ Sweats	☐ Excessive Hunger	☐ Vomiting	☐ Earache	☐ Sinus Problems
		☐ Excessive Thirst	☐ Vomiting Blood	☐ Ear Discharge	☐ Vision – Flashes
		☐ Gas		☐ Hay Fever	☐ Vision - Halos

Muscle, Joint, Bone Pain, Weakness, Numbness in:		Cardiovascular		Skin	
☐ Arms	☐ Hips	☐ Chest Pain	☐ Poor Circulation	☐ Bruise Easily	☐ Rash
☐ Back	☐ Legs	☐ High Blood Pressure	☐ Rapid Heart Beat	☐ Hives	☐ Scars
☐ Feet	☐ Neck	☐ Irregular Heart Beat	☐ Swelling of Ankles	☐ Itching	☐ Sore That Won't Heal
☐ Hands	☐ Shoulders	☐ Low Blood Pressure	☐ Varicose Veins	☐ Change in Moles	

Genito-Urinary	Men Only		Women Only	
☐ Blood in Urine	☐ Breast Lump	☐ Lump in Testicles	☐ Abnormal Pap Smear	☐ Hot Flashes
☐ Frequent Urination	☐ Erection Difficulties	☐ Penis Discharge	☐ Bleeding Between Periods	☐ Nipple Discharge
☐ Lack of Bladder Control		☐ Sore on Penis	☐ Breast Lump	☐ Painful Intercourse
☐ Painful Urination			☐ Extreme Menstrual Pain	☐ Vaginal Discharge

Females: Please complete

Menstrual Flow: ☐ **Regular** ☐ **Irregular** ☐ **Pain/Cramps # of days of flow** _____ **Length of cycle** _____ **Date of last** _____

Number of: Miscarriages: _____ **Pregnancies:** _____ **Births:** _____ **Abortions:** _____

Date of Last: Pap Test _____ ☐ **Normal** ☐**Abnormal** **Mammogram** _____ ☐ **Normal** ☐ **Abnormal**

Conditions: Please ✓ conditions you currently have or have had in the past year

☐ AIDS	☐ Bronchitis	☐ Glaucoma	☐ HIV Positive	☐ Pacemaker	☐ Suicide Attempt
☐ Alcoholism	☐ Bulimia	☐ Goiter	☐ Kidney Disease	☐ Pneumonia	☐ Thyroid Problems
☐ Anemia	☐ Cancer	☐ Gonorrhea	☐ Liver Disease	☐ Polio	☐ Tonsillitis
☐ Anorexia	☐ Cataracts	☐ Gout	☐ Measles	☐ Prostate Problem	☐ Tuberculosis
☐ Appendicitis	☐ Chemical Dependency	☐ Heart Disease	☐ Migraine Headaches	☐ Psychiatric Care	☐ Typhoid Fever
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Miscarriage	☐ Rheumatic Fever	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Scarlet Fever	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Emphysema	☐ Herpes	☐ Multiple Sclerosis	☐ Stroke	☐ Venereal Disease
☐ Breast Lump	☐ Epilepsy	☐ High Cholesterol	☐ Mumps		

Family History: Please ✓ if any blood relative has history of illness and indicate which relative

☐ Alcoholism _____	☐ Cancer _____	☐ Hay Fever _____	☐ Mental Illness _____
☐ Anemia _____	☐ Depression _____	☐ Heart Disease _____	☐ Migraine _____
☐ Arthritis _____	☐ Diabetes _____	☐ Hepatitis _____	☐ Osteoporosis _____
☐ Asthma _____	☐ Epilepsy _____	☐ Hypertension _____	☐ Stroke _____
☐ Bleeding Disorder _____	☐ Glaucoma _____	☐ Lipid Disorder _____	☐ Thyroid Disease _____

Current medications: _____

_____

Vaccine & Year

Tetanus/Td _____ Pneumonia _____
Hepatitis _____ Tuberculosis _____
Influenza (flu) _____

Test/Exam & Year

Eye _____ Dental _____
Rectal/ Stool _____
Cholesterol _____

Hospitalizations: Illness/Operation & Year

_____
_____
_____

Registration Form

gary burnstein community health clinic

First Name _____ MI ____ Last Name _____ M / F Sex _____ Date of Birth

Social Security Number _____

Street Address _____

City _____ County _____ State _____ Zip Code _____

Primary language _____

Contact Information:

Email _____

Cell Phone # _____ Additional Phone # _____ Cell / Home / Work

Race/Ethnicity (Check all that apply)	**Employment Status**	**Marital Status**
☐ Black or African American ☐ White or Caucasian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic ☐ Other_____ ☐ Refused to answer	☐ Employed ☐ Self Employed ☐ Retired ☐ Unemployed	☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner
Referred By: ☐ Hope Warming Center ☐ GCOH ☐ St. Joes ☐ McLaren ☐ Doctors Hospital ☐ Hospital or Medical Facility_____ ☐ MPRI ☐ Other Shelter ☐ Online/211 ☐ Other_____	**Military Status** ☐ Active Duty ☐ Veteran ☐ Retired ☐ Dependent ☐ None	**Homeless** ☐ Yes ☐ No **Disabled** ☐ Yes ☐ No

Emergency Contact (First Name Last Name) _____ Relation to Patient _____

Phone of contact _____ Cell / Home / Work

Medical Coverage: ☐ Yes ☐ No If you have medical coverage, please explain on back of this form. →

Medication Coverage: ☐ Yes ☐ No

I certify that the above information is true to the best of my knowledge. I understand that I may be asked for additional documentation in support. I hereby authorize the Gary Burnstein Community Health Center to release this information to third parties, such as the diagnostic laboratories. I also understand that my information will not be released to third parties and that confidentiality will be maintained.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect July 2, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, coordination, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies
- In response to court and administrative orders and other lawful processes;

- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years. That list will not include disclosures for treatment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- We may have violated your privacy rights,
- We made a decision about access to your health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Gary Burnstein Community Health Clinic
45580 Woodward Avenue
Pontiac, MI 48341
Phone (248)-309-3795
Fax (248)-309-3835

Patient Signature Date