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 medical patient at the Dr. Gary Burnstein Community Health Clinic, please complete the enclosed documents in full and submit them in person at the times listed below:

Monday / Wednesday / Thursday
9am to 4pm

- ☐ **Federal Income Tax Form 1040 for prior tax year.**
  Or (4506-T) Proof of Non-Filing Status from the IRS for last tax year
  If you need help please ask the front desk.
- ☐ **Valid Photo ID/Driver's License/State ID**
- ☐ **Medicaid Denial Letter**
- ☐ **Clinic Empowerment Plan (completed with our staff before 1st appointment)**

In this packet complete the following:

- ☐ **Patient Consent Contract**
- ☐ **Patient Registration Form**
- ☐ **Patient Medical History Form**
- ☐ **Disclosure of Protected Health information**
- ☐ **Notice of Privacy Practice**

Bring all medications, supplements/ vitamins in original containers to your first visit

***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.

We look forward to assisting you!
GBCHC Staff

Revised Jan2020

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.

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

In the event that a patient must cancel an appointment, **we request that all cancelations occurs 24 hours prior to your appointment.** I understand that three "**NO SHOW"** visits are grounds for termination of all clinic services.

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**

Revised Nov 2017

Patient Registration Form

_____ _____ _____/_____/_____
Last Name MI First Name Sex Date of Birth

_____ _____ _____ _____ _____
Social Security Number Street Address City State Zip

_____ (_____) _____- _____ (_____)_____-_____ (_____)_____-_____
Email Home Phone # Cell Phone # Alternate Phone #

_____
Preferred Language

Race/Ethnicity (Choose up to 2):	Employment Status:	Marital Status:
☐ Black or African American ☐ White or Caucasian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic/ Latino ☐ Middle Eastern or North African Descent ☐ Other_____	☐ FT ☐ Retired ☐ PT ☐ Self Employed ☐ Unemployed Income: $_____ yearly Number of person living in household is: _____	☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Separated Disabled: ☐ Yes ☐ No Military Status: ☐ Active Duty ☐ Veteran ☐ Retired ☐ None Homeless: ☐ Yes ☐ No
Medical Coverage: ☐ Yes ☐ No If yes please specify: _____ _____ _____	Religion: ☐ Christian ☐ Jewish ☐ Islam ☐ Buddhist ☐ Hindu ☐ Catholic ☐ Chaldean ☐ LDS ☐ Other _____	Referred By: ☐ Hope Center ☐ Other Shelter ☐ MPRI ☐ Online ☐ 211 ☐ Family/Friend ☐ Food Distribution Hospital/Medical Facility: _____

☐ **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

I certify that the above information is true to the best of my knowledge. I understand that I may be asked for additional documentation to support the information provided above. I hereby authorize GBCHC to release information to appropriate third parties as a continuation of the care received at the clinic. I also understand that my information will not be released to those other than the responsible party and entities which I have written consent.

Patient Signature: _____ Date: _____

Revised Nov 2017

Patient Medical History

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

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

Allergies: ☐ None/Unknown ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Iodine ☐ Bee Stings ☐ Gluten ☐ Latex ☐ Other _____

Please list all medications you are currently taking:

☐ None

_____

_____

Please bring in all medications in original bottles on your first visit.

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

☐ None **General**		☐ None **Digestive**		☐ None **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

☐ None **Muscle, Joint, Bone Pain, Weakness, Numbness in:**		☐ None **Cardiovascular**		☐ None **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	

Women Only

Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain/Cramps | Length of Cycle _____ days Date of Last_____
Number of: Miscarriages: _____ Pregnancies: _____ Births: _____ Abortions: _____
Date of Last: Pap Test:_____ ☐ Normal ☐ Abnormal Mammogram:_____ ☐ Normal ☐Abnormal

☐ Abnormal Pap Smear	☐ Hot Flashes
☐ Bleeding Between Periods	☐ Nipple Discharge
☐ Breast Lump	☐ Painful Intercourse
☐ Extreme Menstrual Pain	☐ Vaginal Discharge

☐ None **Urinary**	☐ None **Men Only**		☐ None **Hospitalizations, Surgeries, and Illnesses**
☐ Blood in Urine	☐ Breast Lump	☐ Lump in Testicles	_____ **Year:** _____
☐ Frequent Urination	☐ Erection Difficulties	☐ Penis Discharge	_____ **Year:** _____
☐ Lack of Bladder Control		☐ Sore on Penis	_____ **Year:** _____
☐ Painful Urination			

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

☐ None	☐ Bronchitis	☐ Glaucoma	☐ HIV Positive	☐ Pacemaker	☐ Suicide Attempt
☐ AIDS	☐ Bulimia	☐ Goiter	☐ Kidney Disease	☐ Pneumonia	☐ Thyroid Problems
☐ Alcoholism	☐ Cancer	☐ Gonorrhea	☐ Liver Disease	☐ Polio	☐ Tonsillitis
☐ Anemia	☐ Cataracts	☐ Gout	☐ Measles	☐ Prostate Problem	☐ Tuberculosis
☐ Anorexia	☐ Chemical Dependency	☐ Heart Disease	☐ Migraine Headaches	☐ Psychiatric Care	☐ Typhoid Fever
☐ Appendicitis	☐ Chicken Pox	☐ Hepatitis	☐ Miscarriage	☐ Rheumatic Fever	☐ Ulcers
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Scarlet Fever	☐ Vaginal Infections
☐ Asthma	☐ Emphysema	☐ Herpes	☐ Multiple Sclerosis	☐ Stroke	☐ Venereal Disease
☐ Bleeding Disorders	☐ Epilepsy	☐ High Cholesterol	☐ Mumps		
☐ Breast Lump					

Family History: Please ✓ if any blood relative has history of illness and indicate which relative ☐ None

☐ 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 _____

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

Who can we share your health information with?

Authorization to

☐ Myself only

Disclose Protected Health Information (Optional)

I authorize The Dr. Gary Burnstein Community Health Clinic to share my health information with the individuals or organizations listed below:

Name	Yes or No	Power of Attorney
Address, City, Zip		Phone Number
Name	Yes or No	Power of Attorney
Address, City, Zip		Phone Number
Name	Yes or No	Power of Attorney
Address, City, Zip		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 Feb2020

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.

Email: The GBCHC will send newsletters and information regarding events, changes, and other health opportunities to patient's personal email to ensure they receive the maximum health opportunities as a patient at our clinic.

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 view or obtain copies of your health information. Written request to obtain access to your health information is required. Copies are provided in a pdf format and given on a computer disk. Alternative formats can be provided upon request. You may request access by sending us a letter to the address at the end of this notice. A nominal fee will be charged for all copy request.

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, complaints 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 also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information.

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

U.S. Department of Health and Human Services
51111 Woodward Avenue
Pontiac, MI 48342
Phone (248)-975-4800
Fax (248)-262-6492

Patient Signature Date