Cedar Hill Medical P.C.
2845 US 2 & 41, Suite 201
Bark River, MI 49807
906-466-2000/Fax 906-466-2067
888-372-3327

WELCOME to Cedar Hill Medical, P.C. We would like to THANK YOU for choosing our practice for your medical care.

Our promise to you is high-quality medical care provided by a compassionate, committed, and friendly team of medical professionals. We want you to have the best possible experience in all areas you come in contact with.

You can find more information about our practice policies at our website, www.cedarhillmedical.com.

If we can assist you in any way, or if you have suggestions about how to improve our service, please contact our office manager, Christine Gitchell at (906)466-2000 extention 2.

Cedar Hill Medical, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex.

Once again, thank you for choosing Cedar Hill Medical, P.C. for your healthcare needs.

ALL OF US AT CEDAR HILL MEDICAL, P.C.

Theodore Oswald, MD
Amber Gustafson, PA-C
Jenni Polfus, FNP-C

C. N. Raveesh, MD
Claire Schultz, FNP-BC

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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POLICIES AND PROCEDURES

There are a couple things we would like to go over with you. They are listed below. This information will help you understand our policies and procedures for our clinic.

- ✓ Our prescriptions are faxed to the pharmacy of your choice. Please allow at least 30-45 minutes for the pharmacy to have your prescription ready for you to pick up. This could vary depending on the pharmacy. Also when calling for a refill, please allow 24-48 hours for the pharmacy to receive your refill information. This also may vary due to weekends or holidays.

- ✓ When you have had any lab work or any testing ordered through our office we will contact you by phone or mail. Some results take several days; we will notify you as soon as possible. If you have not heard from us, please call, we would be happy to follow-up with you.

- ✓ When you call for the doctor or nurse, you will be transferred to the nurse's extension; if she is not there she will return your call as soon as she can. They do check their phone on a regular basis, mainly at lunch and around 3:00 p.m.

- ✓ We would like to receive the co-pays at the time of service. If you do not know your co-pay, please refer to your paperwork or call the number on the back of your card for your next visit.

- ✓ When your visit is for an annual exam, we will need to know if your insurance pays for preventative care. It is your responsibility to let us know, if it is not covered, you will be billed for the days charges.

- ✓ We will bill your insurance and assist you in any way we can, but if your insurance does not pay, it is your responsibility to contact them. Payment arrangements can be made if your insurance does not pay. If monthly payments are not made you will go into in-house collections. The next step will be the collection agency.

- ✓ Our office does not prescribe chronic pain management or ADHD medications for patients over the age of 18.

- ✓ We will request records from your previous physicians if you would like your records transferred to our office. Please keep in mind they will not be able to transfer records from other doctors that they referred you to; those records do not belong to them. A release will need to be filled out for each doctor that you have seen.

By signing below, you acknowledge the information that has been given to you.

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

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☐ Cedar Hill Walk-In Clinic
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AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENTS NAME		**DATE OF BIRTH**	/ /
ADDRESS		**SOCIAL SECURITY #**	- -
CITY, STATE, ZIP		**PHONE NUMBER**	( ) -

I authorize Cedar Hill Medical, P.C. to release/receive the following information

☐ **TO** ☐ **FROM**

ORGANIZATION OR INDIVIDUAL
MAILING ADDRESS
CITY, STATE, ZIP

In compliance with the Federal Health Insurance Portability Act (HIPPA), Cedar Hill Medical, P.C. must keep all medical records and personal information completely confidential. The HIPAA privacy rules give individuals the right to request restrictions on uses and disclosures of their protected health information.

I will be transferring my care to the following provider at Cedar Hill Medical, PC: _____

RECORDS TO BE RELEASED OR RECEIVED: (Please check all that apply)

- **COMPLETE MEDICAL CHART**, including all diagnoses, treatment and/or examination(s) rendered to me
- Office Notes Date(s): _____ to _____
- X-Ray/Ultrasound Results Date(s): _____ to _____
- Laboratory/Pathology Results Date(s): _____ to _____
- Psychotherapy notes as defined in 45 CFR 164.501
- Psychosocial Summary/Treatment Plan
- Excluding: _____
- Other Medical Records: _____

REASON FOR DISCLOSURE: (Please check all that apply)

○ Request of Individual ○ Further Medical Care ○ Legal Investigation or Action ○ Coordination of care
○ Changing Physicians ○ Insurance Eligibility ○ Moving to another location ○ _____

I understand that this release of records authorization will expire in 1 year. **I also understand that disclosure will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information.** I understand that I may revoke this authorization by delivering a written notice to Cedar Hill Medical, P.C. at 2845 US 2 & 41, Suite 201, Bark River, MI 49807. (Exception: if action was taken prior to revocation)

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Representative Signature (for minors, etc): _____ Relationship: _____ DATE: _____

FOR OFFICE USE ONLY:
RECORDS SENT/RECEIVED VIA (Circle): MAIL FAX COURIER DATE: _____ INITIALS: _____

Cedar Hill Medical P.C.

Last Name	First Name	M.I.	Nickname (Name you would like to be called)

Date of Birth	Social Security #	Maiden Name (If applicable)

Marital Status (circle one) Child Single Married Widowed Divorced Separated Other	Sex (circle one) Male Female	Ethnic Group (circle one) Hispanic or Latino Not Hispanic or Latino Declined

Race: Please (circle one) Caucasian (White) African American Native American Hispanic Declined Other

Home Address (if mailing address is different please complete below)			Home Phone
City	**State**	**Zip**	**Cell Phone**
Mailing address			**Work Phone**
City	**State**	**Zip**	**Occupation/Employer**

Preferred Contact Method (circle one) Phone Mail E-Mail	Preferred Reminder Method (circle one) Cell Home Work	Your E-Mail Address

RESPONSIBLE PERSON (If other than patient, person responsible for billing) Guarantor's Name		Relationship to Patient
Guarantor's Date of Birth	**Guarantor's Social Security #**	**Guarantor's Home Phone**
Guarantor's Home Address		**Guarantor's Cell Phone**
City	**State**	**Zip**	**Guarantor's Work Phone**
Guarantor's Employer			**Guarantor's Occupation**

AUTHORIZATION TO RELEASE INFORMATION

I give Cedar Hill Medical, P.C./Cedar Hill Walk-In Clinic, permission to speak with the following people regarding my medical information. This authorization is valid until I provide Cedar Hill Medical, P.C./Cedar Hill Walk-In Clinic written revocation of it.

Primary Emergency Contact Name	Phone Number	Relationship to Patient
Other Contacts	**Phone Number**	**Relationship to Patient**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT The Notice of Privacy Practices for Cedar Hill Medical, P.C. and/or Cedar Hill Walk-In Clinic are available for you to review. I understand that I may request a copy of the notice at any time.

- *I hereby state that all information listed above, to my knowledge, is accurate and give consent for treatment.*
- *I authorize the release of medical information to obtain payment of any benefits available to me to CHM/CHWI for services rendered.*
- *I authorize that direct payment of any benefits available to me be released to Cedar Hill Medical, PC for services rendered.*
- *I also understand that if my insurance company(s) denies payment, because services are not covered under my insurance plan, that I will be responsible for payment or contacting them with any questions on billing. This may include office visits, laboratory or other rendered services.*
- *I authorize the disclosure of my personal health information to obtain payment from third parties that may be responsible for such costs.*
- *I authorize the disclosure of my personal health information electronically to UPHIE. I also understand that I may opt-out of sharing my personal health information by requesting an opt-out form from the front office staff.*
- *I understand it's my responsibility to present correct insurance information at every visit. If I fail to do so I will be responsible for paying my bill in full.*
- ***I have read the back of this registration and am aware that CHM/CHWI is a Patient Centered Medical Home.***

Patient Signature	Date
Parent/Guardian Signature (if applicable)	**Date**

Cedar Hill Medical P.C.

To all Patients,

Thank you for choosing Cedar Hill Medical P.C & Cedar Hill Walk-In Clinic to provide for your health care needs! We are striving to improve the services we offer to you.

We are currently a patient centered medical home. A patient centered medical home is a model of healthcare based on a personal relationship between the patient, provider and the patient's care team. Whatever the medical needs – primary, preventive care, acute care, chronic care, or end-of-life care – the patient has a medical "home". A single, trusted provider and care team, through which continuous, comprehensive and integrated care is provided.

In order to best serve your needs, we must work as a team. Below is a description of your responsibilities and those of the provider.

Patient Responsibilities:

- Make healthy decisions regarding your health
- Prepare for and keep scheduled visits or reschedule visits in advance
- Tell your doctor about any changes in your health status
- Take all medications as prescribed and follow the provider's orders
- End every visit with a clear understanding of your provider's orders, medications, treatment goals and follow up
- Ask questions if unclear
- Come to Cedar Hill Medical P.C./Cedar Hill Walk-In Clinic or call for all medical concerns, **unless it is a medical emergency**

Provider Responsibilities:

- Listen to patient's health concerns, symptoms and questions
- Explain diseases, treatments and results in an easy to understand manner
- Assist patient in medical decision making based on current medical research
- Give clear directions about medications and treatments
- Send patients to trusted experts, when needed
- End every visit with clear instructions about orders, treatment goals, and follow up
- Keep all patient information private
- Provide 24 hour access to medical care, same-day and walk-in appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open

Hours of Operation: Monday-Friday 8-5 EST.

We look forward to working with you to maintain and improve your health.

The Providers and Staff at:
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Patient Financial Responsibility Statement

Thank you for choosing Cedar Hill Medical, P.C. as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit at a self-pay reduced rate. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Deductibles will be sent to you via a statement by mail after your insurance processes your claim. Once a statement is sent payment is due within 30 days. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Forms of payment. Our office accepts Visa, Mastercard, check, and cash payments for medical expenses.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit, our office will do our best to notify you if this is the case.

Proof of insurance. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not part of that contract.

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Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 90 days past due, you will receive a final call stating that you have to pay your account in full. Partial payments will be accepted and payment plans are also available. If a balance exceeds $250 then a payment plan will need to be signed in order to continue treatment with our clinic. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party/Date

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