Restorative Health Care
2855 Capital Avenue SW
Battle Creek, MI 49015
Phone: (269) 979-6200
Fax: (269) 979-6201

Dear:

We are pleased to welcome you as a new patient. Our primary mission at Restorative Health Care is to deliver high quality care to our patients. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible.

To assist you with your specialty care, we provide the following payment options for any out-of-pocket costs you have based on your insurance contract which include any co-pays, deductibles and/or co-insurance balances:

1. Cash – includes money orders and personal checks
2. Credit Card – we accept VISA, MasterCard, Discover and American Express
3. CareCredit (for Cosmetic procedures only which includes Vein Treatments, Botox and CoolSculpting) – If you do not already have CareCredit and want to see if you qualify we can submit an on-line application and have a response back within minutes.

We are happy to offer these choices so that you can select a payment option that best fits your needs.

We look forward to seeing you at your scheduled appointment with John Koziarski, MD, Carrie Palmer, PA-C or Bethany Huffman, PA-C on

_____ at _____ am / pm

Again, we are pleased to welcome you to Restorative Health Care.

Sincerely,

Providers and Staff

RESTORATIVE HEALTH CARE

MEDICAL HISTORY **DATE:** _____

NAME: _____ **DOB:** _____ **AGE:** _____

FAMILY DOCTOR: NAME _____ PRACTICE _____

REFERRING DOCTOR: NAME _____ PRACTICE _____

REASON FOR THIS VISIT: _____

_____

_____

CHILDHOOD ILLNESSES: MEASLES _____ MUMPS _____ CHICKENPOX _____ RHEUMATIC FEVER _____ ASTHMA _____

SEIZURES _____ POLIO _____ OTHER _____

ADULT MEDICAL ILLNESSES: ASTHMA _____ EMPHYSEMA _____ GERD _____ ULCERS _____ KIDNEY STONES _____

KIDNEY DISEASE _____ HEART DISEASE _____ HYPERTENSION _____ STROKE _____ OSTEOARTHRITIS _____

DIABETES _____ HEPATITIS _____ GLAUCOMA _____ DEPRESSION _____ SLEEP APNEA _____

PREVIOUS SURGERIES: TONSILLECTOMY _____ GALLBLADDER _____ APPENDECTOMY _____ BREAST BIOPSY _____

HEART _____ HERNIA _____ C-SECTION _____ HYSTERECTOMY _____ / OVARIES REMOVED? YES NO

OTHER _____

HAVE YOU EVER HAD A COLONOSCOPY? YES NO

CURRENT MEDICATIONS: (Please list "ALL" medications you are taking, including dosage and bring the bottles with you)

_____ _____

_____

_____

MEDICATION ALLERGIES: _____

FAMILY HISTORY: EARLY HEART DISEASE _____ HYPERTENSION _____ STROKE _____ DIABETES _____

CANCER (List type and which family member):_____

OTHER _____

SOCIAL HISTORY: OCCUPATION _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

DO YOU SMOKE? YES NO HOW LONG? _____ YEARS / IF YOU QUIT SMOKING, HOW LONG AGO? _____YEARS

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____

DO YOU CONSUME CAFFEINE? YES NO HOW MUCH? _____

ILLICIT DRUGS: YES NO / IF YES, PLEASE LIST _____

PATIENT NAME: _____ **DATE:** _____

REVIEW OF SYSTEMS: (Please circle and/or enter information for all)

GENERAL: **Change in Appetite:** Yes / No - If Yes, Increase / Decrease **Chills:** Yes / No

Fatigue: Yes / No **Fever:** Yes / No **Lightheadedness:** Yes / No

Weight Gain or Loss: Yes / No - If Yes, Gain / Loss, How Much? _____ Over How Long? _____

EYES: **Blurred Vision:** Yes / No **Discharge:** Yes / No **Itching/Redness:** Yes / No **Pain:** Yes / No

EARS/NOSE/THROAT: **Hoarseness:** Yes / No **Thyroid Disease:** Yes / No - If Yes, Overactive? or Underactive?

Decreased Hearing: Yes / No **Difficulty Swallowing:** Yes / No - If Yes, Solids? and/or Liquids?

Swollen Glands: Yes / No

RESPIRATORY: **Cough:** Yes / No **Coughing up Blood:** Yes / No

Shortness of Breath: Yes / No - If Yes, At Rest? or With Movement? **Wheezing:** Yes / No

CARDIOVASCULAR: **Heart Murmur:** Yes / No **Chest Pain:** Yes / No - If Yes, At Rest? or With Movement?

Irregular Heartbeat: Yes / No **Palpitations:** Yes / No

GASTROINTESTINAL: **Stomach Ulcers:** Yes / No **Colon Polyps:** Yes / No

Prior Colonoscopy: Yes / No - If Yes, When? _____ **Food Intolerance:** Yes / No

Abdominal Pain: Yes / No **Blood in Stools:** Yes / No **Constipation:** Yes / No

Diarrhea: Yes / No **Hepatitis:** Yes / No **Heartburn:** Yes / No

Nausea: Yes / No **Rectal Bleeding:** Yes / No **Vomitting:** Yes / No

GENITOURINARY: **Blood in Urine:** Yes / No **Frequent Urination:** Yes / No **Painful Urination:** Yes / No

MUSCULOSKELETAL: **Artificial Joints:** Yes / No - If Yes, Knee? / Hip? / Shoulder?

Painful Joints: Yes / No **Swollen Joints:** Yes / No

PERIPHERAL VASCULAR: **Leg Swelling:** Yes / No **Restless Leg Syndrome:** Yes / No **Blood Clots:** Yes / No

Cold Extremities: Yes / No **Numbness:** Yes / No - If Yes, Hands? / Feet?

Pain/Cramping in Legs: Yes / No - If Yes, At Rest? or With Walking?

Painful Extremities: Yes / No **Leg Ulcers:** Yes / No

SKIN: **Rash:** Yes / No **Skin Cancer:** Yes / No **Skin Lesions:** Yes / No

NEUROLOGIC: **Stroke:** Yes / No **Mini-Stroke(TIA):** Yes / No **Fainting:** Yes / No

Headache or Migraines: Yes / No - If Yes, Headaches? or Migraines?

Seizures: Yes / No - If Yes, when was the last one? _____ **Numbness/Tingling:** Yes / No

WOMEN ONLY:
BREAST: **Lumps:** Yes / No **Pain:** Yes / No **Nipple Discharge:** Yes / No

OTHER:
Number of Pregnancies: _____ **Number of Live Births:** _____ **History of Birth Control Pills:** Yes / No

History of Hormone Replacement: Yes / No **Age at First Pregnancy:** _____ **Age at Last Pregnancy:** _____
Menopause: Yes / No - If Yes, What Age? _____

RESTORATIVE HEALTH CARE

PATIENT DEMOGRAPHIC INFORMATION
(PLEASE PRINT)

PATIENT NAME: _____ **SEX: M / F**
First Middle Last Suffix

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

ETHNICITY/RACE: (CIRCLE ONE) American Indian/Alaska Native / Asian / Black/African American / Hispanic/Latino

Native Hawiian / Other Pacific Islander / White / Other: _____

HOME PHONE #: _____ **WORK PHONE #:** _____

CELL PHONE #: _____ **ALTERNATE PHONE #:** _____

WHICH IS THE BEST <u>"DAYTIME"</u> # TO CALL: (CIRCLE ONE) HOME WORK CELL ALT

E-MAIL ADDRESS: _____

PLACE OF EMPLOYMENT: _____

FAMILY DOCTOR: NAME _____ PRACTICE _____

PHONE # _____ FAX # _____

REFERRING DOCTOR: NAME _____ PRACTICE _____

PHONE # _____ FAX # _____

SPOUSE'S NAME: _____
First Middle Last Suffix

SPOUSE'S DATE OF BIRTH: _____ **SPOUSE'S SOCIAL SECURITY #:** _____

SPOUSE'S PLACE OF EMPLOYMENT: _____

SPOUSE'S PHONE # WITH AREA CODE: _____ **(Circle One) Cell / Home / Work**

PREFERRED PHARMACY (Name & Location): _____

.....

<u>Please list an emergency contact (someone other than spouse) not living at your address:</u>

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ **PHONE NUMBER:** _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ **PHONE NUMBER:** _____

_____
PATIENT SIGNATURE **DATE**

Notice of Privacy Practices for FamSurg, PLC d/b/a Restorative Health Care

Effective Date of this Notice: January 1, 2015

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting Sara Kranz, Privacy Officer/ Office Manager at (925)-933-2962
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures - How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications /Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety

Do research- We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

RESTORATIVE HEALTH CARE
MEDICAL INFORMATION RELEASE

Patient Printed Name:_____

I understand that as part of my healthcare, this practice originates and maintains records describing my health information and I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

Signature of patient or patient's representative: _____

Date: _____

One-Time Authorization for Patients with Medicare Coverage

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Signature of patient or patient's representative: _____

Date: _____

Notice of Privacy Practice Acknowledgement

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH RESTORATIVE HEALTH CARE'S NOTICE OF PRIVACY PRACTICES – Effective Date of Notice: January 1, 2015

Signature of patient or patient's representative: _____

Date: _____

Person(s) to whom my medical information can be released

Name: _____ Relationship: _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of patient or patient's representative: _____

Date: _____

RESTORATIVE HEALTH CARE
2855 CAPITAL AVENUE SW
BATTLE CREEK, MI 49015
PHONE: 269-979-6200 FAX: 269-979-6201

MEDICAL INFORMATION FORMS

At Restorative Health Care we understand that our patients may receive forms from insurance companies, disability carriers, and employers that must be completed by our medical staff during your course of treatment. These forms request confidential medical information about you, including your diagnosis and treatment, your work status, and your recovery. Before we can complete a medical information form or release medical information about you we must have a signed authorization from you.

If you receive a medical information form from your insurance company, disability carrier, or employer that you would like our medical staff to fill out, bring it to our office and speak with a member of our billing staff. You will be asked to sign a consent form authorizing us to release information about you. You will also be asked to pay a fee for completion of certain forms by our medical staff.

Completion of medical information forms such as FMLA and Disability is not a free service; we require payment in advance. The charge for completion of these forms is $20.00 and must be paid prior to the form being completed.

If we receive a form in the mail or by fax requesting medical information about you or asking for a copy of your medical record, we will call and ask you to come into the office, sign a consent form and pay any applicable fees before we can complete the form or copy your medical records.

It generally takes 5 to 7 working days to review your chart and complete your medical information form. Completed forms are held at the front desk for patient pick-up unless you make other arrangements with us when you drop off your form. If you do not receive a telephone call from our office advising you that your completed form is ready, please call us before coming to the office in case your form is not yet completed.

Thank you for your cooperation

RESTORATIVE HEALTH CARE

Patient Provider partnership:

Our goal at Restorative Health Care is to establish a partnership between you the patient, your family, caregivers and patient advocate(s), along with the health care team at Restorative Health Care. Doing so will allow you to make decisions that are respectful of the physician's knowledge and experience, and will ensure the patient's wants, needs and personal preferences are met. Our team at Restorative Health Care is dedicated to providing the best possible care to every person that entrusts us with their care. We are only able to do this if you, the patient work with our team to accomplish this goal.

Our Promise to You

- Explain diseases, treatments, and test results in an easy-to-understand way
- Listen to your feelings and questions to help you make decisions about your care
- Coordinate the delivery of your services through effective communication, coordination, and integration with your other providers, recognizing your Primary Care Provider as having the overall responsibility for the coordination and integration of your care
- Protect the integrity and confidentiality of your treatments, discussions, and medical records, only disclosing information in a secure manner
- Provide 24 hour access to answer questions about the care we provide to you whenever possible
- Make meeting your care needs easier by the use of computers and health information technology (electronic medical record, patient portal, etc.)
- To care for you to the best of our abilities based on our understanding of current medical methods available in our specialty
- Give you clear directions about medications and other treatments
- End every visit with clear instructions about expectations, treatment goals and future health care plans

What We Expect of You

- Ask questions, share your feelings, and be a part of your care.
- Be honest about your medical history, symptoms, and other important information about your health
- Tell us about any changes in your health and well-being
- Take all of your medicine and follow our advice to you
- If you are unable to follow the advice we provide to you, let us know
- Make healthy decisions about your daily habits and lifestyle
- Keep scheduled appointments or reschedule appointments in advanced whenever possible
- Call us with any problems or questions you have related to the care we provide to you
- End every visit with a clear understanding of our expectations, treatment goals, and future plans for your health care

Billing Policy

The providers and staff of Restorative Health Care would like to welcome you and thank you for choosing us for your specialty needs. We would like to provide you with some introductory information concerning the financial aspects of your encounter in hopes of avoiding any confusion or concerns which may be caused by the somewhat complex process of medical billing as it exists today.

If you are a new patient, when you first contact or are contacted by our office, you will likely be questioned about the type of insurance by which you are covered. This will allow our staff to ensure that the proper referral documents can be obtained to avoid nonpayment of your visit(s). Rest assured that in no way does insurance coverage or non-coverage affect the type of care you receive.

If you are an established patient you will be asked to update your personal information and notify our office of any changes in insurance coverage since your last visit.

At the time of your visit, you will be responsible for any co-payment portion dictated by your insurance carrier. If you are covered by more than one type of insurance, (for example, Medicare and Blue Cross) please let the receptionist know so the proper carriers can be billed.

As with your office visits, you may be responsible for a portion of the procedure fees (deductibles and/or co-insurance) depending on insurance type and policy coverage. Our Financial Policy states after insurance pays on your claim(s) you will receive a statement from our office once the balance becomes patient responsibility. Any account over 30 days old is considered past due.

Our primary mission at Restorative Health Care is to deliver the best care possible to our patients. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. To assist you with your specialty care, we provide the following payment options once your insurance carrier has processed your claim(s):

1. **Cash-Includes money orders and personal checks**
2. **Visa/MasterCard, Discover and American Express**
3. **Care Credit (for Cosmetic procedures only – Vein Treatments, CoolSculpting & Botox)**

Payment plans are available with very specific criteria in some instances. Please speak with the Billing Manager or Administrator if you are unable to pay with the options listed above. Arrangements must be made in advance.

Thank you once again for choosing us for your specialty medical care. We will assist you in whatever way possible and we ask that you assist us by understanding your insurance policy and the coverage it provides. Although we make every effort to be accurate and concise in our billing process, oversights do at times occur. Please do not hesitate to contact our billing department to answer your questions.

Providers and Staff of Restorative Health Care

Billing Policy Confirmation

I have received and read the Billing Policy provided to me by Restorative Health Care.

I understand I am responsible for any co-payment, co-insurance, and/or deductible amount dictated by my insurance carrier. I understand the payment options available to me.

Patient Signature_____Date_____

_____Date_____
Signature of Responsible Party (if patient is a minor)