Christopher J. Noah, MD
4525 N. M-37 Hwy. Suite M
Middleville, MI 49333

Phone: (269) 205-2900
Fax: (269) 205-2899

Welcome!

Thank you for your interest in becoming a patient. To better serve you, we ask you please read the enclosed new patient information packet. The packet includes our privacy policies, patient center medical home, patient medical history, as well as information about our office. We ask you to get the packet back to us filled out completely before we schedule your first appointment. We will also need your insurance card and photo ID.

Once we receive the information we need from you, we will call you to schedule your first visit.

Due to the longer length of time we allow for the first appointments, we require at least 24 hours' notice for cancellation or rescheduling. Your failure to do this could result in permanent cancellation as a patient here and possibly your family members.

If there are any questions you have prior to your visit, please do not hesitate to call the office. We are open every weekday except Tuesday.

Thank you for choosing Middleville Family Practice. We look forward to meeting you.

Sincerely

Middleville Family Practice

www.middlevillefamilypractice.com

REGISTRATION FORM

Middleville Family Practice **Christopher Noah, MD** **Ph:269 205 2900**

Name: _____ Date of Birth: _____
Last First Initial

Marital Status _____ Sex: Male Female Other Social Security # _____

Address _____ (H) Phone: _____
Street

_____ Cell Phone: _____
City State Zip

Employer _____ (W) Phone: _____ Email: _____

Race_____ Ethnicity: Hispanic or Non-Hispanic (please circle one) Primary Language spoken _____

Health Insurance Name _____ **ID#**_____ **Group#**_____

If you are married and you have insurance through their employer, please fill this out:

Name of Spouse: _____ Date of Birth: _____ SS# _____

Guarantor Information (Under 18 Years of age)

Father's Name _____ Mother's Name _____
Date of Birth _____ Date of Birth _____
SS# _____ SS# _____
Employer _____ Employer _____

Emergency Contacts

#1_____
Emergency Contact (Relationship) (Phone)

#2_____
Emergency Contact (Relationship) (Phone)

Middleville Family Practice complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

By signing below, I acknowledge that I have received Middleville Family Practice's Notice of Privacy Practices. I understand that I may request additional restrictions on the use and disclosure of my health information.

I authorize Christopher Noah, MD to bill my insurance company, releasing any medical information required regarding exams and treatment. Patients with insurance hereby authorize any insurance benefits to be paid directly to Christopher Noah, MD. I understand that I am responsible for any balance that my insurance company does not cover such as co-pays, coinsurance or deductibles. Self-pay charges are due at the time services are rendered.

(Signature) (Date)

Patient Medical History Form

For Christopher Noah, MD

Patient Name:_____ DOB: _____Date:_____

Please list **SPECIAL PROBLEMS** you would like evaluated today in order of significance:

1.

2.

3.

4.

MEDICATION ALLERGIES: (Such as penicillin) What happens when you take that medication :

_____

MEDICATIONS: Prescriptions:

Medication: **Dosage:** **Frequency:**

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

PAST MEDICAL HISTORY:

Please describe and give dates of any illnesses and surgeries:

_____

_____

_____

MIDDLEVILLE FAMILY PRACTICE

Patient name _____ Date of Birth _____

Authorization
PEOPLE INVOLVED IN PATIENT CARE

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give my permission for staff within Middleville Family Practice to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had, either in hospitals or other locations.

I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.

I know that listing a person on this form does not allow them to get a copy of my medical records.

People listed on this form are not allowed to give consent for services for me.

For a minor, parents are assumed to be designated except for those services which the minor has given consent under Michigan law.

LIST PEOPLE THAT MAY RECEIVE VERBAL INFORMATION ABOUT YOUR CARE

NAME OF PERSON	**RELATIONSHIP**	**CONTACT PHONE NUMBER**

_____ I do NOT wish to name anyone. (if initial)

The following information has special protection under Michigan law and will be made available to the people listed above ONLY if I give my approval by initialing in the lines.

_____ HIV/AIDS or other diseases – tuberculosis, hepatitis, venereal diseases, sexually transmitted diseases.

_____ Substance abuse services

_____ Mental Health services

I can update this form at any time by telling a Middleville Family Practice staff member and by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to Middleville Family Practice staff member.

PATIENT SIGNATURES

I have read this form and I understand it. All my questions have been answered.

_____

Patient signature DATE

Middleville Family Practice
Christopher Noah, MD
4525 N M-37 Hwy Suite M
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Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip _____

INFORMATION REQUESTED

□ History & Physical	□ Discharge Summary	□ Emergency Reports	□ EEG/ ECG
□ Operative Reports	□ Labs/ Path Reports	□ Billing Invoices	□ Blood Type
□ Radiology Reports	□ Progress Notes	□ Reports	□Immunizations
□ Consults Letters	□ Other _____		

I authorize my records to be sent **From:**

Name_____
Address_____
_____
Phone_____

I authorize my records to be released **TO:**

Middleville Family Practice, Christopher Noah, MD
4525 N M- 37 HWY Suite M
Middleville, MI 49333
Fax 269 205 2899

Purpose of Disclosure:

□ Patient request □ Attorney/Legal □ Insurance □ Continued Patient Care

Other _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person, except as required by law. I further understand that correspondence, patient discharge instructions and records from other health care providers will be released with this routine request.

If you DO NOT WANT to release any of your specially Protected Information (PHI) in the categories below, check the box(es) for that category:

□ Information about communicable diseases and serious communicable diseases and infections, and defined by state and Michigan Department of Public Health Rules, which include venereal disease, tuberculosis TB, hepatitis B, human immunodeficiency virus HIV, HIV test, acquired immunodeficiency syndrome AIDS, and AIDS released complex.

□ Alcohol and drug abuse treatment information protected under the regulation in 42 code of Federal Regulations, Part 2.

□ Mental health treatment records, psychological services and social services information, including communication made by me to a social worker or psychologist.

□ The release of my DNA test results regarding a diagnosis of _____

This authorization will expire sixty days from the date of my signature, unless I specify otherwise: _____

This authorization may be revoked in writing at any time. There is potential that information disclosed under this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protested categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 on 1974 as amended) and also by Title 42 of the Code of Federal Regulations, Part II. In this case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

Welcome to our Practice

Your Patient-Centered Medical Home!

We will continue to:

- Provide you with a care team who will know you and your family
- Give care that meets your needs and fits with your goals and values
- Have a doctor on call 24 hours a day and 7 days a week
- Take care of acute illnesses, long term disease and give advice to help you stay healthy

You may notice that:

- We ask what your goal is, or what you want to do to improve your health
- We ask you to help us plan your care, and to let us know if you think you can follow the plan
- Our care team members providing for your complete care through new roles and tactics
- We remind you when preventative care services are due so that you have the best receive the best quality care.

We trust you, our patient, to:

- Tell us what you know about your health and illnesses
- Tell us about your needs and concerns
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- Let us know when you see other doctors and what medications they put you on or change
- Ask other doctors to send us a report about your care when you see them
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Keep your appointments as scheduled, or call and let us know when you cannot
- Give us feedback so we can improve our services

AVAILABLE COMMUNITY SERVICES

NEED HELP? DIAL 211 FROM ANY PHONE AND YOU WILL BE CONNECTED WITH A REFERRAL HOTLINE THAT CAN CONNECT YOU WITH NON-PROFIT AGENCIES IN THE AREA THAT CAN HELP WITH HUMAN, HEALTH AND SOCIAL NEEDS (I.E., UTILITIES, HOUSING, HEALTH INSURANCE, FOOD, DIAPERS, ETC.)

A LISTING OF THE AREA RESOURCES CAN ALSO BE FOUND ON THE AUNT BERTHA WEBSITE: **https://www.findhelp.org**

PLEASE ASK OUR STAFF FOR INFORMATION PERTAINING TO YOUR SPECIFIC NEEDS.

A Patient-Centered Medical Home (PCMH) is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

URGENT CARE

We strive to accommodate patients who need more urgent care. Please call us to see if we can see you or guide your care. Often, we might guide you to care that serves you well.

LAB TEST RESULTS

Please try to use laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. If you have not received a call within 14 days, please call the office for your results.

Comprehensive Quality of Care

Please be aware, in the course of providing your care, your health care information may be shared among other Providers involved in your care, as appropriate.

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PRACTICE HOURS

Monday: 9:00am – 5:00pm
Tuesday: CLOSED
Wednesday: 9:00am – 5:00pm
Thursday: 9:00am – 5:00pm
Friday: 9:00am – 5:00pm

https://www.middlevillefamilypractice.com/

Middleville Family Practice

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your Protected Health Information (PHI) private in accordance with the Notice of Privacy Practices. At Middleville Family Practice, we understand that your health information is highly personal and we are committed to safeguarding your privacy. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> *Treatment.* Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
>
> *Payment.* Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> *Health Care Operations.* Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions

regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies or your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12 month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we mend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.

We support your right to protect the privacy of your medical 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.

Contact Us

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Privacy Officer
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