McLAREN MEDICAL GROUP
ADULT REGISTRATION

Language Preference: ❘ English ❘ Other specify: ______

PATIENT INFORMATION

PATIENT NAME (Last) (First) (Middle)	❑ Male ❑ Female	STATUS: ❑ Single ❑ Married ❑ Divorced ❑Widowed

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE ( )	SS# | | |–| | |–| | | |	BIRTH DATE | |–| |–| | | |
CELL PHONE ( )	E-MAIL ADDRESS	

LANGUAGE:	ETHNICITY:	RACE:
❑ English ❑ Spanish ❑ Arabic ❑ German ❑ Polish ❑ French ❑ Italian ❑ Chinese ❑ Declined	❑ Hispanic/ Latino ❑ Non-Hispanic/ Latino ❑ Decline to Answer ❑ Unknown	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White Caucasian ❑ Native Hawaiian or Pacific Islander ❑ Unknown or Decline to Answer

EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE ( )

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE PHYSICIAN	REFERRED OR RECOMMENDED BY

For appointment reminders only, use phone number ______ and E-mail ______

For leaving a message, use phone number ______

SPOUSE /LEGAL GUARDIAN INFORMATION

NAME (Last) (First) (Middle)	RELATIONSHIP

TELEPHONE ( )	SS# | | |–| | |–| | | |		BIRTH DATE | |–| |–| | | |

ADDRESS	CITY	STATE	ZIP CODE

Type text here

EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE ( )

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE		SUBSCRIBER	BIRTH DATE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME

SECONDARY INSURANCE		SUBSCRIBER	BIRTH DATE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP CODE

WORK TELEPHONE ( )	HOME TELEPHONE ( )

EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE ( )

PATIENT/LEGAL GUARDIAN SIGNATURE	**DATE**

UPDATES

DATE	SIGNATURE	DATE	SIGNATURE

CONSENT AND AUTHORIZATION

MEDICAL GROUP

1. GENERAL CONSENT TO ADMISSION AND TREATMENT

I, the undersigned, hereby voluntarily request, consent to and authorize all medical and hospital care, including physical examination and screening, diagnostic procedures, drug administration, therapeutic treatments, including drug and alcohol screening, as deemed necessary in the judgment of the attending physician(s), other medical staff members and health care providers of McLaren Health Care subsidiaries ("McLaren"). I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me with respect to the results of the care and treatment that I have received.

I hereby authorize McLaren to retain, preserve and use for scientific or teaching purposes, or to dispose at its discretion or convenience, any specimen or tissues taken from my body during my visit. I authorize McLaren to photograph, film and/or record me for the purpose of diagnosis, treatment recommendation and/or documentation and identification while in treatment. I understand that these photographs, films, and/or recordings may be retained as a permanent part of the medical record and may be used for case studies and education. I have been informed and understand that most McLaren facilities are teaching institutions and that the medical and surgical procedures performed may require the observation, cooperation and services of multiple health care providers. I authorize such persons to undertake this observation, service and care.

2. CONSENT FOR EXPOSURE TESTING

I understand if an emergency responder, health care professional, or other health facility employee is exposed to my blood or body fluid, that testing including but not limited to HIV, Hepatitis B or Hepatitis C may be performed without my consent, as mandated by MCL 333.20191.

3. RELEASE OF INFORMATION FOR INSURANCE

I authorize McLaren and its affiliates to release to any third party payer, or its representative, including Medicare, Medicaid, Champus, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological service records including communications by me to a social worker or psychologist.

4. RELEASE OF INFORMATION FOR PUBLIC HEALTH

I authorize McLaren to release information contained in my medical record, including information about communicable diseases and/or infections, as defined by Michigan statute and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, and alcohol and/or drug abuse information protected under the regulations in 42 Code of the Federal Regulations part 2, psychiatric/

PATIENT
NAME:

DATE OF BIRTH:

psychological records, and social work records, including communications to a social worker, psychiatrist or psychologist.

5. **ASSIGNMENT OF INSURANCE BENEFITS**

I assign and authorize direct payment to McLaren of all health benefits and other forms of payment relating to the care provided to me by McLaren staff. I assume full financial responsibility for payment of all expenses associated with my care and treatment, including any charges not paid by insurance. These expenses may include, but are not limited to, daily charges for telephone calls, patient-requested private room, and any deductible and coinsurance amounts.

6. **TELEPHONE CONSUMER PROTECTION ACT**

I understand that, from time to time, McLaren, its subsidiaries and affiliates (collectively, "McLaren") may contact me to (1) discuss any past, current or future services provided by McLaren, as permitted under HIPAA; (2) discuss the accounting, billing or other financial information (such as insurance information and service fees) for past, current or future services provided by McLaren; and (3) discuss collections of any past due amounts or my eligibility for payment assistance or forgiveness programs.

I consent and agree to McLaren and its service providers (a) contacting me at any address (including e-mail) or telephone number (including wireless number or ported landline phone number) that I may provide to McLaren; (b) using automated phone dialing systems or prerecorded message calls when contacting me; and (c) sending text messages to my phone number, to carry out the purposes McLaren has identified above. I agree to McLaren sharing my contact information, including my wireless number and e-mail address, with service providers (including a collection agency) with whom McLaren contracts to assist it in pursuing these interests, but I understand that McLaren will not share my phone number(s) with third parties for their own purposes without my consent. I understand that standard telephone minute and text charges may apply.

I further understand that I do not have to consent to receive autodialed or prerecorded message calls or texts to receive services from McLaren. I may choose to revoke my consent for receiving autodialed or prerecorded message calls or texts by contacting a McLaren Customer Representative to inform them of my preferences using the following toll-free number or email address: **(844) 839-3884 or phonecalloptout@mclaren.org.**

7. **MULTIPLE DATES OF SERVICE**

I understand that my treatment may require more than one date of service, therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment; I understand that treatment may be rendered at any McLaren facility.

8. **AUTHORIZATION TO OBTAIN MEDICATION RECORDS FOR CARE COORDINATION**

I understand that it is important for my care providers to know what medications I am currently taking, in order for them to prescribe and provide the appropriate treatment for me. I therefore give permission for McLaren/Karmanos to obtain and review records from any pharmacy (or pharmacies) which I currently obtain medication(s) from.

PATIENT NAME:

DATE OF BIRTH:

CONSENT AND AUTHORIZATION

9. FOR PREGNANT OR NEW POST-PARTUM PATIENTS

I understand that McLaren is required to perform screening tests for HIV, Hepatitis B and sexually transmitted infection whenever a pregnant patient initially presents for prenatal treatment or delivery (or immediately after delivery if an infant was delivered outside of the hospital) and test results are not readily available to the care provider. By signing this form I consent to having these tests performed.

10. RELEASE OF RESPONSIBILITY: PERSONAL VALUABLES

I understand that McLaren is not liable for the loss or damage to any personal property that I choose to keep with me or in my room during my McLaren stay, and that I am responsible to make arrangements to keep items of value secured. I have been advised to send all personal valuables home. I also acknowledge that McLaren/Karmanos is not responsible for personal items brought in to me during my stay.

__________ (Patient Initials) ___________ (Patient Access Rep. Initials)

11. NOTICE OF PRIVACY PRACTICES

I have received a copy of McLaren's Joint Notice of Privacy Practices, Grievance Procedure, Patient Rights, and Visitation Policy (if applicable):

__________ (Patient Initials) ___________ (Patient Access Rep Initials)

Notices Provided, Patient Returned/Refused ___________ (Patient Access Rep Initials)

12. HEALTH INFORMATION EXCHANGES

I understand that McLaren participates in Health Information Exchanges or business operations and to make my health care information available to other providers who may treat me.

13. MEDICARE BENEFICIARIES HOSPITAL ADMISSIONS ONLY

I have received a copy of "An Important Message from Medicare"

__________ (Patient Initials) ___________ (Patient Access Rep Initials)

14. TRICARE BENEFICIARIES HOSPITAL ADMISSIONS ONLY

I have received a copy of "An Important Message from Champus"

__________ (Patient Initials) ___________ (Patient Access Rep Initials)

I certify that I have read this consent form, or that it has been read to me. I understand its contents and agree that by signing this form I am bound by its provisions, whether signed by myself or a representative acting on my behalf.

______________________________ ______________________________

PATIENT Signature (Parent/Guardian, if Minor, or person signing on patient's behalf) Date/Time **(MANDATORY)**

PATIENT NAME:

DATE OF BIRTH:

CONSENT AND AUTHORIZATION

Relationship if other than patient	Telephone Permission By
Witness	Date/Time (**MANDATORY)**
2nd Witness (Permission By Telephone)	Date/Time (**MANDATORY)**

PATIENT
NAME:

DATE OF BIRTH:

McLaren Midland ENT **Candice C Colby, MD**

Date________________ Referring Physician______________________________ Height______ Weight_______

Name______________________________________ Date of birth__________________________ Age________

REASON FOR TODAY"S VISIT:

____

____

PAST MEDICAL HISTORY

Do you have any of the following conditions?

High Blood Pressure	yes	no	COPD/Emphysema	yes	no	Thyroid Problems	yes	no
Heart Disease	yes	no	Asthma	yes	no	Stomach Problems	yes	no
Heart Attack	yes	no	Liver Problems	yes	no	Neurologic Problems	yes	no
Diabetes	yes	no	Kidney Problems	yes	no	Cancer type________________		

Other chronic illnesses or past illness/injuries?____

____

PAST SURGICAL HISTORY-Please list all past surgeries and year:

____

____

ANESTHESIA COMPLICATIONS? YES NO

CURRENT MEDICATIONS: (please include prescription and over the counter medications and amount of each):

____

____

____

DRUG ALLERGIES (please list drug allergy and reaction):

____

FAMILY HISTORY Please complete the following regarding your immediate family.

HAS ANY FAMILY MEMBER HAD ANY PROBLEMS WITH THE FOLLOWING:

	Family member (list who)		Family member (list who)
Ear disease	____________	Thyroid disease	____________
Hearing loss	____________	Allergies	____________
Cancer	____________	Musculoskeletal disease	____________
High Blood Pressure	____________	Bleeding	____________
Heart Disease	____________	Hematologic/lymphatic	____________
Stroke	____________	Neurological disease	____________
Anesthesia problems	____________	Diabetes	____________
Other:	____________		

OVER->

McLaren
MEDICAL GROUP

Needs Assessment

Patient Name (First, Last) ______________________________ **Date of Birth** __________________

Date of Assessment: ______________

Patient: Please fill out the information below to better assist us with your care.

Our goal is to educate our patients in order to provide the best possible care. Would you consider yourself ready to learn? ☐ Yes ☐ No

Learning Preference	**Cultural Considerations**
Check all that apply.	Do you have any religious or cultural practices that we should be aware of?
☐ Demonstration	☐ Yes ☐ No If Yes, please describe: ______________________________
☐ Video	**Communication Needs**
☐ Read Instructions	Do you have impaired vision or are blind? ☐ Yes ☐ No
☐ Picture Instructions	Can you read? ☐ Yes ☐ No
☐ No preference	Can you write? ☐ Yes ☐ No

Language Preference
☐ English ☐ Other, please list ______________________________
Do you need an interpreter? ☐ Yes ☐ No
Are you deaf? ☐ Yes ☐ No Do you use sign language? ☐ Yes ☐ No ☐ NA
Safety
Do you keep fire arms in the home? ☐ Yes ☐ No
If you answered Yes, do you take safety precautions with firearms in the home? ☐ Yes ☐ No ☐ NA
Abuse
Violence and/or sexual abuse is a problem for many people, which is why we routinely screen all patients for violence or abuse in their lives. Are you experiencing violence and/or sexual abuse? ☐ Yes ☐ No

Fall Risk	Clinical Staff: If Yes checked for any Fall Risk question, was Fall Prevention Education given? ☐ Yes ☐ No ☐ NA, give reason ______________
Have you fallen in the last year? ☐ Yes ☐ No	
Do you experience forgetfulness or confusion? ☐ Yes ☐ No	
Do you use a walker or cane? ☐ Yes ☐ No	
Depression Screening	Clinical Staff: If Yes checked for either Depression Screening question, the Provider will complete a PHQ-9 screening.
Over the past 2 weeks, have you experienced any of the following:	
Little interest or pleasure in doing things ☐ Yes ☐ No	
Feeling down, depressed or hopeless ☐ Yes ☐ No	

Advanced Directive
Do you have an Advanced Directive, which is written instructions for your family and health care provider in the event that you cannot make a decision about your care? ☐ Yes ☐ No
Would you like information on Advanced Directives? ☐ Yes ☐ No ☐ NA
Clinical Staff: If Yes checked for Advanced Directive, was information given? ☐ Yes ☐ No

Information Given by: __________________ Relationship to Patient (if not self) ____________ Date __________

Clinical Staff only
Reviewed by:
Provider's Signature (Required) ______________________ Date & Time (Required) ______________

PERSONAL HISTORY:

Are you presently working? _______ Occupation:___________________________

Marital Status ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Do you drink alcohol? _____ Amount consumed per WEEK: ________ Do you drink caffeine? _____Amount consumed per DAY: ________

Have you ever used tobacco? ☐ Yes ☐ No, not currently ☐ Never
started (year): _______ quit (year): _______
how many/how much per day? ___________________________

Do you currently or have you ever used illicit drugs (marijuana, cocaine, meth)? _____

REVIEW OF SYSTEMS Please circle yes or no if you experience any of these problems:

CONSTITUTIONAL			CARDIOVASCULAR			ENDROCINE			RESPIRATORY		
Fever/Chills	yes	no	Chest pain	yes	no	Increased Appetite	yes	no	Wheeze	yes	no
Weight loss/Gain	yes	no	Irregular Pulse	yes	no	Decreased Appetite	yes	no	Cough	yes	no
Excessive Fatigue	yes	no	Tightness in chest	yes	no	Excessive thirst	yes	no	Coughing Blood	yes	no
Night sweats	yes	no	Swelling in Feet/Hands	yes	no	Hormone Problems	yes	no	Shortness of Breath	yes	no
EARS			**NOSE**			**THROAT**			**MUSCULOSKELETAL**		
Drainage from Ears	yes	no	Nosebleeds	yes	no	Sore Throats	yes	no	Joint Pain or Swelling	yes	no
Hearing loss	yes	no	Nasal Congestion	yes	no	Hoarseness	yes	no	Arm or leg weakness	yes	no
Ear Pain	yes	no	Nasal Drainage	yes	no	Difficulty swallowing	yes	no	Back Pain	yes	no
Ringing in Ears	yes	no	Sinus Headaches	yes	no	Mouth Sores	yes	no	Muscle Aches	yes	no
GASTROINTESTINAL			**EYES**			**NEUROLOGICAL**			**HEMATOLOGIC/LYMPHATIC**		
Indigestion	yes	no	Glaucoma	yes	no	Seizures	yes	no	Bleeding tendencies	yes	no
Nausea/Vomiting	yes	no	Cataracts	yes	no	Memory Problems	yes	no	Persistent swollen glands	yes	no
Diarrhea	yes	no	Double/Blurred Vision	yes	no	Speech Problems	yes	no	Night Sweats	yes	no
Constipation	yes	no	Vision Change	yes	no	Headache	yes	no	Easy Bruising	yes	no
Abdominal Pain	yes	no	Watery/Itchy Eyes	yes	no	Facial weakness	yes	no	Anemia	yes	no
PSYCHIATRIC			**GENITOURINARY**			**INTEGUMENTARY**			**ALLERGIC/IMMUNOLOGIC**		
Anxiety	yes	no	Difficulty Urinating	yes	no	Skin Rash	yes	no	Food Allergies	yes	no
Depression	yes	no	Painful Urination	yes	no	Sores	yes	no	Nasal Allergies	yes	no
Insomnia	yes	no	Blood in Urine	yes	no	Skin cancer	yes	no	Autoimmune Disease	yes	no

Other: ____________________

The information provided in this form is accurate to the best of my knowledge.

____
Patient Signature Date

____
Parent signature if patient is minor Date

I HAVE REVIEWED THE INFORMATION WITH PATIENT OR PARENT

____
Physician Date

McLAREN HEALTHCARE

Authorization to Release Information

Patient Name ____________ Birthdate ____________ Medical Record Number ____________

Address ____________

Phone Number ____________ Maiden/Other Names ____________

I authorize ____________ (name) ____________ (address) ____________ (city,state,zip) ____________ (telephone/fax)

to release to Dr. Candice Colby-Scott (name)
(address) 801 JOE MANN BLVD, SUITE H
(city, state, zip) MIDLAND, MI 48642
(telephone/fax) P: 989-794-9210
(email address) F: 810-600-7886

Specific type of information to be disclosed: **Date(s) of Service:** All Records

- ☒ History and Physical
- ☒ Operative Report
- ☒ Physician's Notes
- ☒ Consultation Reports
- ☐ Therapy Notes
- ☐ Discharge Summary
- ☒ Laboratory Results
- ☐ Billing Records
- ☐ Home Care Records
- ☒ Diagnostic Imaging (e.g., X-Rays) reports from (date) ____________
- ☐ Diagnostic Imaging (e.g., X-Rays) films from (date) ____________
- ☐ Other ____________

Sensitive information to be disclosed: **Date(s) of Service:** ____________

- ☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes)
- ☐ Referrals and treatment for alcohol and substance use disorder
- ☐ Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

☐ **Consent to release Entire Medical Record, for dates of service listed, including all information noted above:**

Date(s) of Service: ____________ ____________ **Initials** **Date**

Please continue to the otherside of this form for Acknowledgements and signatures.

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PT.
MR.#/P.M.
DR.

By signing this form I understand:

1. That I need not sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.

2. My health information may be shared electronically.

3. The sharing of my health information will follow state and federal laws and regulations.

4. This form does not give my consent to share psychotherapy notes as defined by federal law.

5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

6. I should tell all agencies and people listed on this form when I withdraw my consent.

7. I can have a copy of this form.

8. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

9. That any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

10. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

__________________________________ __________________

Signature of Patient or Legal Representative Date

____

If Signed by Legal Representative, State Relationship to Patient

__________________________________ __________________

Signature of Witness Date

PT.

MR.#/P.M.

DR.