Downriver Medical Associates
Compassionate Care You Deserve

Date_____

PATIENT INFORMATION

Name _____ Date of Birth _____

Social Security # _____-_____-_____

Address _____

_____

Phone Number: Home _____ Cell _____

Sex: Male_____ Female _____

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Employer_____

Occupation_____ Full Time_____ Part Time_____

Primary language_____ Interpreter Needed: No_____ Yes_____

INSURANCE (If the patient is NOT the subscriber):

Subscriber Name_____

Relationship: Mother_____ Father_____ Spouse_____

Subscribers Date of Birth _____

Emergency Contact _____

Relationship_____ Phone Number _____

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Due to the many changes in insurance policies, I understand it is my responsibility to know my individual insurance coverage. Failure to comply with this could result in my being responsible for all costs.

I have supplied Downriver Medical Associates with all applicable insurance information. I consent to all medical care deemed necessary in the judgement of the physicians at this facility, including but not limited to, diagnostic procedures, x-rays, and laboratory studies.

I understand that this facility and its staff are authorized to release any information necessary to collect payment for services rendered.

I have read and understand that it is my responsibility to work with my insurance company and comply with my individual insurance contract regulations. If I fail to comply with the rules and regulations, according to my individual policy, I will be responsible for all costs incurred.

_____ _____

Patient/Guardian Signature Date

2300 Biddle Ave., Suite 100 * Wyandotte, MI 48192 * P: 734.246.5705 F: 734.246.5750

HEALTH HISTORY QUESTIONNAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical record

Name _____ Date of Birth _____

(First) (Middle) (Last)

Sex: Male_____ Female _____ Height _____

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Tobacco Use: Current_____ Former_____ Never_____

Types: (Circle one) cigarettes, pipes, cigars, chew, snuff

Packs a day_____ Years smoking_____ Quit Date_____

Alcohol Use: Yes_____ No_____ How many drinks a week_____ Types of alcohol_____

Drug Use: Yes_____ No_____ Use in a week_____ Types_____

Sexually active: Yes_____ No_____ Not Currently_____ Partners: Male_____ Female_____

Past Medical History

Past Surgical History	**Laterality**	**Date**	**Comments**

Allergies	**Reactions**

Depression Screening:

Little interest or pleasure in doing things?

Several days_____ More than half the days_____ Nearly every day_____ Never_____

Feeling down, depressed, or hopeless?

Several days_____ More than half the days_____ Nearly every day_____ Never_____

Pharmacy: Name_____ City_____

Medication List:

Name	Dosage	Frequency	Route (i.e. by mouth)

Family History:

	Age/Sex	Significant Health Problems		Age/Sex	Significant Health Problems
Mother			Children	○ M ○ F	
Father				○ M ○ F	
Siblings	○ M ○ F			○ M ○ F	
	○ M ○ F			○ M ○ F	
	○ M ○ F		Grandfather Maternal		
	○ M ○ F		Grandmother Maternal		
	○ M ○ F		Grandfather Paternal		
			Grandmother Paternal		

Personal Health History:

Immunizations	Date(s)	Immunizations	Date(s)
Influenza		Tdap	
Hepatitis A		Hepatitis B	
Chickenpox		MMR	
Tetanus		Prevnar	
Shingles		Gardasil	
COVID-19		Other:	

Emergency Contact Name_____ Ph#_____

Relationship_____

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Medical Information Release Form

(HIPAA Release Form)

Name _____ Date of Birth _____

(First) (Middle) (Last)

Release of Information

Check one:

[ ] I authorize the release of information including the diagnosis, records, examination(s) rendered to me and claims information. This information may be released to:

[ ] Spouse (full name): _____

[ ] Child(ren) (full name/s): _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

2300 Biddle Ave., Suite 100 * Wyandotte, MI 48192 * P: 734.246.5705 F: 734.246.5750

PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

Patient Rights:

DMA has adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:

1. Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
2. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
3. Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
4. Access protective and advocacy services or have these services accessed on the patient's behalf.
5. Appropriate pain and symptom management.
6. Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
7. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
8. Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
9. Receive as much information about any proposed treatment as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternative courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
10. Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
11. Formulate advance directives regarding his/her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives (to the extent provided by the state laws and regulations).
12. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
13. Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
14. Realase of records to designated
15. Realease
16. Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language impaired patient will be appropriate to the impairment.
17. Access information contained in his or her medical record within a reasonable time frame.
18. May obtain or inspect his/her medical records and a third party shall not be given a copy without authorization of the patient except as required by law and third-party contract (usually within 30 days of the request and a nominal fee may apply).
19. Reasonable responses to any reasonable request he/she may make for service.
20. Leave the facility even against the advice of his/her physician.
21. Reasonable continuity of care.
22. Be advised of the facility's grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
23. Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
24. Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
25. Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.
26. Examine and receive an explanation of his/her bill regardless of source of payment.
27. Know which facility rules and policies apply to his/her conduct while a patient.
28. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
29. May request another provider if another qualified provider is available.
30. Will not be discharged, harassed, retaliated or discriminated against because a patient has exercised rights protected by law.
31. Know if physician has any ownership in the practice.

All facility personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.

Patient Responsibilities:

The care a patient receives depends partially on the patient. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:

1. The patient has the responsibility to provide accurate and complete information concerning his/her current complaints, allergies to environment, food and medication(s) and current and past illnesses, hospitalizations, medications and other matters relating to his/her health.
2. The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
3. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

Patient Responsibilities Cont'd:

4. The patient is responsible for following the treatment plan established by his/her practitioner, including the instructions of nurses and other health professionals as they carry out orders.
5. The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
6. The patient is responsible for fulfilling financial obligations of his/her care as promptly as possible.
7. The patient is responsible for following facility policies and procedures.
8. The patient is responsible for being considerate of the rights of other patients and facility personnel.
9. The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.
10. The patient is responsible for notifying the physician, in writing, of any living will, medical power of attorney, or other directive that could affect the patient's care.

If you think that we may have violated your patient rights, or you disagree with a decision we made, you may file a written complaint with:

Downriver Medical Associates

2300 Biddle Ave STE 100

Wyandotte MI 48192

You may also call us to voice a grievance or complaint at: 734-246-5705

If you believe your concerns have not been adequately addressed, you may contact:

Michigan Department of Licensing and Regulatory Affairs Bureau of Health Care Systems
Complaint Investigation Unit
P.O. Box 30664
Lansing, MI 48909
www.michigan.gov/bhcs, toll-free complaint hotline at 800-882-6006

Visit www.medicare.gov and select "Ombudsman" under "Help & Support" to get information about how your Medicare questions and complaints are handled, or call 1-800-MEDICARE (1-800-633-4227)

_____ _____
Patient Printed Name Patient Signature Date

_____ _____
Witness Date

Reviewed: 2.24.2021 CE