Ascension
St. John

New Patient Checklist

Dear Patient,

PLEASE BRING THE FOLLOWING ON THE DAY OF YOUR APPOINTMENT:

1. COMPLETED NEW PATIENT FORM
2. ALL INSURANCE CARD(S) PRIMARY AND SECONDARY IF APPLICABLE
   ATTENTION HMO INSURED PRIMARILY BCN/HUMANA PATIENTS PLEASE HAVE YOUR GLOBAL REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT
3. LIST OF ALL MEDICATIONS INCLUDING THEIR DOSAGES
4. CURRENT VALID DRIVERS LICENSE OR PICTURE ID

THANK YOU IN ADVANCE.

Great Lakes Cancer Management Specialists
Laura A. Biernat, MD, FACP • Jerome E. Seid, MD, FACP • Carrie L. Dul, MD, FACP • Wajahat A. Khan, MD, FACP• Daniel Lebovic, MD, FACP • Elon Knoll, MD • Hosam Hakim, MD • Adam Biedny DO • Tarik Hadid MD • Judy Casalou, PA •Tina Gastmeier, NP•Lauren Sauve, NP•Jessica Fisher, NP•Gail Grunkemeyer, NP

Van Elslander Cancer Center 19229 Mack Avenue, Suite 24 Grosse Pointe Woods, MI 48236
T: 313-884-5522 **F:** 313-884-6054
Macomb Medical Campus 17900 23 Mile Road, Suite 402 Macomb Township, MI 48044
T: 586-868-9090 **F:** 586-868-9005
The Webber Cancer Center 11800 E. 12 Mile Road, Warren, MI 48093
T: 586-576-1615 **F:** 586-576-1628
River District Doctors Park 4014 River Road, Building 1 East China Township, MI 48054
T: 810-326-1583 **F:** 810-326-1553

Great Lakes Cancer Management Specialists

PRACTICE HOURS

MONDAY THROUGH FRIDAY

8:30 am. - 5:00 pm.

- Should you have an AFTER-HOURS issue please contact the office for your Hematology/Oncology needs. We will direct you with the next steps.

- Should you have an issue not pertaining to care you received from our office, please contact your Primary Care Physician.

- Should you need a refill on a medication that was prescribed to you from our office, please contact the office during business hours.

Ask any of our staff about Community Services or contact the following:

NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected to a referral hotline that can connect you with non-profit agencies in your 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 website:

https://www.referweb.net/uwjc

Ask about our Patient Web Portal.

We Have a Patient Portal that supports two-way, secure and compliant communication.

New Patient Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____

Cell Phones: _____

Work/alternate Phone: _____

Email: _____

Date of Birth: _____

Social Security No: _____

For Office Use

Date Called: _____

Appt Date & TIme: _____

Location: ☐ RDCC ☐ GPW

☐ Macomb ☐ Warren

Physician: _____

Insurance: _____

Ins ID No.: _____

Referral/Auth required: ☐ Yes ☐ No

Auth No.: _____

Secondary Ins: _____

Medical Records: ☐ Pt prov ☐ Fax ☐ Other

Reason for Referral: _____

_____

Referring Physician: _____

In what language do you prefer to discuss your healthcare? _____

Would you like an interpreter? ☐ Yes ☐ No

Do you have any learning barriers? ☐ Yes ☐ No

How do you want to receive information? ☐ Written ☐ Hearing ☐ Viewing ☐ Reading

Do you require any assistance such as a sign language interpreter? ☐ Yes ☐ No

Do you have an **Advance Directive**? ☐ Yes ☐ No

☐ Power of Attorney ☐ Patient Advocate ☐ Living Will ☐ DNR

(Please provide a copy of the above checked so we can make a copy for your file.)

Would you like information regarding Advance Directives? ☐ Yes ☐ No

Level of Education (Check highest achieved): ☐ Elementary ☐ Junior high ☐ Some High School

☐ High School Graduate ☐ Some college ☐ Associate's Degree ☐ Bachelor's Degree

☐ Some Grad School ☐ Master's degree ☐ MD ☐ PhD ☐ Other advanced degree

Ascension St. John

Specialist-Patient Provider Agreement
Great Lakes Cancer Management Specialists
As a part of your Patient-Centered Medical Home Neighborhood,
We welcome you to our specialty practice!

A Patient-Centered Medical Home Neighborhood (PCMH-n) is a system of care in which a team of health professionals work together to provide your entire healthcare needs. You, the patient, are the most important part of the PCMH-n. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

We are partnering with your Primary Care Physician (PCP) who is your Patient Centered Medical Home. We are sharing their commitment to effectively and efficiently work together to manage your care. As your Specialist, we will be sharing information about your condition and provide recommendations, guidance and periodic follow-up.

As our patient, we trust you to:

- Keep your appointments as scheduled or call and let us know when you are unable to keep your appointment.
- Make healthy decisions about your daily habits and lifestyle.
- Seek the advice of your PCP before you see other physicians.
- Follow the care plan that is agreed upon or let us know why you cannot follow the plan, so we can try to help you.
- Tell us what medications you are taking.
- See your PCP for all preventive services.

As your Specialist, I will:

- Communicate with your Primary Care Physician (PCP) and provide timely written reports.
- Notify your PCP of no-show and/or canceled appointments and other actions that may place your care in jeopardy.
- Notify your PCP if you are being referred to another specialist.
- Remind you of testing due and inform you of the results.
- End every visit with clear instructions about expectations, treatment goals and how I will coordinate with your PCP.

Coordination of care and communication back to your Primary Care Physician is my priority. Should you have other physicians managing your care, please inform them that we are the specialist clinic managing your condition and that communication is required regarding any of their treatments that may interfere with your treatment plan.

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Consent to Distribute Information

In general, the HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health Information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondences to the patient's office instead of the patient's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone: _____ ☐ Cell#: _____

☐ Okay to leave detailed message

☐ Leave message with call-back number only

☐ Work telephone: _____

☐ Okay to leave a detailed message

☐ Leave message with call-back number only

☐ Written Communication

☐ May mail information to my home address

☐ Okay to mail to my work address

☐ Okay to fax information to: Name _____ Fax no: _____

☐ Other: _____

To give information to other physicians, spouses, significant others, family members or guardians, we must have written permission. Please state whom it is okay to give your personal health information.

Emergency contact information and persons with whom we may discuss your care:

Emergency Contact	Relationship	Phone Number	Email address

Are you interested in our online patient information portal? ☐ Yes ☐ No

Patient's Signature: _____ Date: _____

Ascension St. John Hospital & Medical Center

Great Lakes Cancer Management Specialists

Dear Patient and/or Family Member,

Please indicate if you have had any of the following.

Thank you.

PROCEDURE	YES	NO	APPROXIMATE DATE	PHYSICIAN/LOCATION
PNEUMONIA VACCINE				
INFLUENZA VACCINE				
COLONOSCOPY				
CT COLONOGRAPHY *(Virtual Colonoscopy)*				
FECAL IMMUNOCHEMICAL DNA TEST (FIT-DNA) -OR- OTHER COLON CANCER SCREENINGS *-Please specify-*				
SIGMOIDOSCOPY				
RADIATION THERAPY			*Approx Start Date:* *Location/Target Area:*	
HOSPITALIZATION *-In the last 12 months-*			*Approx. Admission Date:* *Approx. Discharge Date:*	

FEMALES ONLY

CERVICAL SCREENING (PAP)				
WERE YOU TESTED FOR HPV AT THE TIME OF YOUR PAP? *(Human Papillomavirus)*				
BREAST SCREENING (Mammogram/US/MRI)			MAMMO | US | MRI	

PLEASE PRINT NAME: _____ BIRTHDATE: _____

SIGNATURE: _____ DATE: _____

Physician Information

We have a multidisciplinary approach to our treatment plan. Therefore it is important to list the physicians you routinely follow up with so that we may coordinate your care and send reports to them.

Specialty	Name
Primary Care or Family Doctor	
Medical Oncologist	
Radiation Oncologist	
Cardiologist	
Pulmonologist	
Gastroenterologist	
Referring Doctor	
Surgeon	
Ob-Gyn	
Other	

Medication Information (Check if list of medications is attached ☐)

Are you currently taking medications, vitamins, supplements, or herbal remedies? ☐Yes ☐No

Please list all medications, vitamins, supplements or herbal remedies you take on a regular basis.

Medication/Vitamin	**Dose**	**Route**	**Frequency**

Are you currently taking any blood thinners? (i.e. aspirin, Coumadin, Lovenox, Pradaxa Eliquis, Other) ☐Yes ☐No If yes, when was your last dose? _____

What is your preferred pharmacy?

Pharmacy Name: _____

Pharmacy address: _____

Pharmacy Number: _____

Do you have prescription coverage? ☐Yes ☐No

Do you have any allergies? ☐ Yes ☐No

Please list any drug or food allergies that you have.

Drug or food Allergy	**Reaction**

Medical History

Please check any problems that you have currently

- ☐ recent breast change
- ☐ Congestive Heart Failure I50.40
- ☐ Arrhythmia/Atrial Fibrillation I48.91
- ☐ High Blood Pressure I10
- ☐ Hepatitis Liver Disease K71.6/K75.9
- ☐ Jaundice
- ☐ Kidney Failure/Dialysis
- ☐ Diabetes E11.9
- ☐ Peripheral Vascular Disease
- ☐ Cancer Type _____
- ☐ Blood Clots
- ☐ home oxygen
- ☐ Sleep Apnea
- ☐ Dementia
- ☐ Heart Disease
- ☐ Bleeding Tendency/Bruising
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Asthma J45.909
- ☐ Emphysema/COPD J44.9
- ☐ Anemia/Leukemia
- ☐ Stomach Ulcers K25.9
- ☐ Epilepsy/Seizures
- ☐ Thyroid Disease E07.9
- ☐ High Cholesterol E74.8/E78.5
- ☐ Heart Attack I25.2 Date: _____
- ☐ HIV/AIDS
- ☐ stroke163.9

Prior cancer treatment: ☐ chemotherapy (Last Date) _____

☐ radiation (Last Date) _____

Please list any other medical problems:

_____

_____

Please circle any of the following problems you currently have or have experienced in the recent past (within the last 6 months).

System symptoms

Constitutional: unexpected weight loss, weight gain, fever, chills, fatigue, insomnia, decreased appetite

Eyes: corrective lenses, blurred/double vision, eye pain, redness, watering, glaucoma, cataracts, yellow eyes

Ears/nose: hearing loss, nose bleeds, ringing in ears, ear infections, earaches

Mouth/throat: sores, difficulty swallowing, painful swallowing, hoarseness, dental problems, dry mouth

Cardiovascular: chest pain, palpitations, fainting, murmurs

Pulmonary: short of breath, wheezing, cough, tightness, snoring

Gastrointestinal: heartburn/GERD, nausea, vomiting, constipation, diarrhea, bloody/tarry stools, hemorrhoids, abdominal pain, bloating burping, hiccups

Genitourinary: frequency, urgency, difficult/painful urination, flank pain, impotence, blood in urine, up at night, bladder disease, kidney stones

Musculoskeletal: joint pains/arthritis, swelling, redness, muscle pain, walk with cane or walker, back pain

Skin: Skin changes, poor healing, rash, itching, redness, yellowing of skin

Psychiatric: anxiety, depression, hallucinations, sexual dysfunction

If there are any symptoms not listed above, that you are currently having or have had in the past, please list them here: _____

_____

_____

Surgical history

Have you had any surgeries? ☐ Yes ☐ No

Type of Surgery	Date of Surgery	Name of surgeon/hospital

Habits

Do you smoke? ☐ Yes ☐ No, I quit. ☐ Never smoked

If yes, how many packs per day? _____ How many years? _____

If you quit, when did you start smoking? _____ When did you quit? _____

How many packs did you smoke per day? _____

Any other form of tobacco use? _____ Marijuana? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per day/week/month/year? _____

IV drug use ☐ Yes ☐ No Please specify _____

Do or did you ever abuse prescription or illegal drugs? ☐ Yes ☐ No

Home Situation

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Who do you or the patient live with? _____

Do you feel safe at home? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No Are you on disability? ☐ Yes ☐ No

Occupation: _____ Employer: _____

Type of industry: _____

Retired: ☐ Yes ☐ No If yes, when did you retire? _____

Full-time ☐ Yes ☐ No Part-time ☐ Yes ☐ No Dependents ☐ Yes ☐ No

Family History

Relation	Alive or deceased	Age	Cause of Death
Mother			
Father			
Sibling (brother/sister)			
Sibling (brother/sister)			
Child			
Maternal Grandmother/Grandfather			
Paternal Grandmother/Grandfather			

Have any of your blood relatives had:

Cancer ☐ No ☐ Yes, Who? _____ What kind? _____ Age of onset? _____

_____

Bleeding Disorder ☐ No ☐ Yes, Who? _____

Race/Ethnicity

Dear Patient:

We are required by the State of Michigan to report statistics on race, ethnicity and preferred language for our patient population. YOUR NAME and ANY OTHER PATIENT IDENTIFIERS OR SPECIFICS WILL NOT BE REPORTED.

Date: _____

Patient Name: _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not hispanic or Latino
- ☐ Unreported/Declined to report

Race:

- ☐ Asian
- ☐ Native Hawaiin
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ More than one race
- ☐ Unreported/Declined to report

Preferred Language:

- ☐ English
- ☐ Indian (Including Hindi and Tamil)
- ☐ Spanish
- ☐ Russian
- ☐ Other

Ascension St. John Hospital

Medicare co-insurance liability notice

Our practice is a **"provider-based"** department of **Ascension St. John Hospital** and complies with rules established by the Centers for Medicare & Medicaid Services (CMS) for provider-based departments. These rules require that we provide you with a notice of your potential financial liability for the hospital services you will receive at this location.

Q: What does "provider-based" mean?
A: "Provider-based" means this location is a hospital outpatient department and services rendered here are billed as hospital outpatient department services. This is a common model for large, integrated delivery systems like Ascension Michigan, where the hospital owns space and employs the staff who work in the department.

This model benefits our patients, as all departments of the hospital are subject to rigorous quality standards and are monitored by The Joint Commission, an independent, not-for-profit organization that accredits and certifies more than 17,000 healthcare organizations. The Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Q: How does this affect the billing process?
A: This designation means the billing for services will be done as a hospital outpatient department and that you may receive two separate bills. Because care is provided in a department of the hospital, patients will receive a bill from the hospital, as well as a separate bill for the professional services provided by their physician. This also includes any professional fees for physicians who interpret the results of diagnostic tests. Patients are responsible for the total co-insurance amount on the services they receive.

Q: What is "co-insurance"?
A: "Co-insurance" is when the cost of your medical care is split between you and your health insurance company on a percentage basis. For example, you may be responsible for paying 20% of the cost of service, and your plan covers the remaining 80% of the costs of service. These co-insurance amounts are determined by Medicare and your health insurance company, and are based on the services performed. Patients are encouraged to check with their insurance provider and ask about their benefits for outpatient hospital services.

CMS rules applicable to provider-based departments require that we provide you with an estimate of your co-insurance amounts. This estimate is based on typical and average charges for visits to our facility. **Please note, however, that your exact co-insurance amounts will vary based on the type and number of services you have received at our department.**

Example of average co-insurance amounts:

	Facility fee	Professional fee	Total co-insurance
Moderate treatment	$19.25	$10.35	$29.60
Severe treatment	$19.25	$22.79	$42.04

I have received a copy of this notice of co-insurance liability and understand that any example provided is not a complete statement of charges and may not reflect my total responsibility for the services I receive.

*Patient signature:*_____

*Date:*_____

Ascension
St. John Hospital

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St. John

INSURANCE AUTHORIZATION and MEDICAL INFORMATION RELEASE

Dear Patient,

We are required to have your signature on file. In that we utilize computer generated claim forms, we would appreciate your signing below in lieu of signing the actual claim form.

_____

Patient Name

_____

Insurance Company Name and Policy/Contract Numbers

"I authorize the release of any medical information necessary to process this claim and further authorize payment of the medical benefits to the provider listed below for services rendered."

_____

Patient Signature **Date**

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Patient rights and responsibilities

Your Rights:

As a patient at an Ascension Michigan facility, you have the right:

1. To be involved in decisions about the care, treatment, and services provided. These decisions include the right to receive or refuse care, treatment, and services without coercion, discrimination or retaliation, or having someone of your choice exercise your rights if you are incapable of doing so, in accordance with laws and regulations. You will be asked to consent to treatment or services that have been explained to you in terms you understand.
2. To create an Advance Directive and have the hospital staff comply with these directives. The existence or lack of an Advance Directive shall not affect your right to access care, treatment, and services.
3. To execute a do-not-resuscitate order on your behalf and have the hospital staff follow it. Your patient advocate may also execute a do-not-resuscitate order on your behalf, in accordance with applicable law and regulations. You or your patient advocate may revoke a do-not-resuscitate order at any time and in any manner by which you are able to communicate your intent to revoke the order, and such revocation shall immediately become a part of your permanent medical record.
4. To be informed about the outcomes of the care, treatment, and services provided, including any unexpected outcomes.
5. To receive appropriate care regardless of your race, creed, culture, religion, national origin, language, color, age, disability, marital status, sex, sexual orientation, gender identity or expression, level of income or source of payment.
6. To receive respectful attention to your confidentiality, privacy, dignity, and security.
7. To exercise your religious practice, and cultural and personal values, beliefs and preferences, within legal and safety guidelines.
8. To have the person of your choice informed, as soon as possible, when you are admitted to an Ascension Michigan facility. You also have the right to have your private physician contacted.
9. To know the name, professional status, and relationship of any provider of care, treatment or services to the Ascension Michigan facility, and to know the reason for any proposed change in the professional staff responsible for your care.
10. To receive assistance with your communication needs, including translation/interpretation services and other communication aids, to assure that you are able to participate in your plan of care.
11. To be informed of any research studies that could be offered to you. You have the right to refuse to be part of such research studies without compromising access to, and quality of, your care.
12. To expect that your report of pain will be believed and addressed.
13. To have your wishes addressed relating to end-of-life decisions, including organ donation.
14. To confidentiality of your clinical record, to view your record, and to obtain, within a reasonable time, a copy of your record, including any completed laboratory test results. There may be a charge for this. You have the right to refuse the release of your clinical record to a person outside of Ascension Michigan facility, except as may be required by law, the right to request an amendment to the medical record and the right to obtain information on disclosures of his or her health information.
15. To be free from mental, physical, sexual and verbal abuse, neglect, and exploitation while at an Ascension Michigan facility. You have a right to access protective and advocacy services.
16. To be free from restraints, except in emergency situations. Your doctor can order restraints only when necessary to protect you and others from injury.
17. To receive, within a reasonable period of time, an itemized bill for services rendered, and to be informed of the source of payment for your services.
18. To be informed about the recording or filming of your care, treatment and services, which can be useful for many purposes. In order to not compromise your privacy and confidentiality, we will obtain your consent for recording or filming. Recording or filming includes photographic, video, electronic or audio media. When the recording or filming is used internally for performance improvement or education, your consent is part of the general consent to treatment form. When the recording will be used for external purposes such as marketing, you will be asked to sign a separate consent that indicates the use of the recording or film. You have the right to request that any recording or filming be stopped.
19. To be informed about Ascension Michigan rules and regulations that affect patient care and conduct.
20. To be provided information about Ascension Michigan policies and procedures for initiation, review, and resolution of patient concerns.
21. To have complaints and concerns from you or your family addressed in a timely manner.
22. To a clean and safe environment. Ascension Michigan facilitates an ongoing proactive program exists for identifying risks and improving patient safety.
23. To designate a support person who will provide you with emotional support during the course of your stay unless the individual's presence infringes on others' rights, compromises safety, or is medically or therapeutically contraindicated.

Ascension

24. To receive and designate visitors of your choosing, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Ascension Michigan shall not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. You may withdraw or deny your consent to receive a visitor at any time.
25. To question whether you are ready to be discharged or transferred to another facility.
26. To be made aware of the reason for your transfer, either within or outside of the hospital.
27. To receive assistance and information to prepare you and your family for when you leave the hospital.
28. To select the provider for your post-hospital care, including the choice of home health agency, medical equipment provider, or nursing home.
29. To access protective and advocacy services.

Your Responsibilities:

We expect patients and visitors to follow Ascension Michigan 's rules and regulations. These rules protect you and other patients.

1. Participate to the fullest extent possible in my care and treatment.
2. Provide complete information about my healthcare condition and medical history, report my care and health risks as I perceive them, and ask questions when I do not understand what I've been told about my care.
3. Notify my care provider or physician about changes in my condition.
4. Notify my care provider or physician of symptoms or healthcare problems, even if they are not related to my primary healthcare condition.
5. Report my pain and participate in the development of a pain management plan with my care provider or physician.
6. Inform my care provider or physician if I do not understand instructions or if I will be unable to follow them.
7. Accept the consequences of my actions if I choose not to participate in the recommended treatment plan.
8. Observe safety regulations.
9. Be considerate of patients, families and staff; help control noise and disturbances; and follow the smoking policies of the organization.
10. Not threaten or harm other patients, families or staff.
11. Not destroy the property of patients, families, staff and facilities.
12. Fulfill the financial obligations of my healthcare as promptly as possible.
13. Ask about test results - do not assume no news is good news.
14. Provide accurate identification and information related to insurance coverage

Expressing Your Satisfaction and Concerns:

You and your relatives have a variety of ways to express your satisfaction and concerns regarding the care experience. You or your family may voice concerns to:

1. Any Ascension Michigan associate.
2. Your care provider or physician.
3. The director of the clinic or hospital department.
4. The Patient Relations Department/Patient Liaison.

We encourage you to resolve complaints immediately at the time of service. If you feel that any of your concerns/complaints have not been resolved to your satisfaction you may initiate a formal grievance by writing or calling:

Ascension St. John Hospital
Patient Relations Department
22101 Moross Road
Detroit, MI 48226
PH: 313-343-3349

You also have the right to contact any of the following agencies:

1. The Centers for Medicare and Medicaid Services 1-800-MED-ICARE (633-4227). For the hearing impaired 1-877-486-2048.
2. The State of Michigan, Licensing and Regulatory Affairs (LARA), Bureau of Health Care Services by calling the complaint line 1-800-882-6006 or by going to their website at http://www.michigan.gov/bhs.
3. The State of Michigan, Licensing and Regulatory Affairs (LARA), Bureau of Health Care Services, Health Professions Division, allegation hotline 1-517-335-9700.
4. The Joint Commission by calling 1-800-994-6610, to receive automated instructions on how to file a patient safety event. They are 1) by website www.jointcommission.org. 2) by fax 630-792-5636 or 3) by mail to the Office of Quality and Patient Safety (OQPS), The Joint Commission, One Renaissance Boulevard, Oakbrook Terrance, IL 60181.
5. If you are a Medicare Beneficiary and have a quality of care concern, you may call Livanta at 1-888-524-9900. If you are hearing impaired, you may call TTY at 1-888-985-8775.

If you are a patient in the hospital and at any time you feel unsafe and may hurt yourself or others, please let your caregiver know immediately. If you are not a patient in a hospital and at any time feel unsafe and may hurt yourself or others, either call 911 or go to the nearest emergency room. You may also call the National Suicide Prevention Lifeline 24 hours a day, 7 days a week 800-273-8255.

Ascension Michigan
Notice of Privacy Practices

1. **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.**
2. **WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**
   We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.
   However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each Ascension Michigan facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at www.ascension.org/michigan
3. **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.**
   We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

   3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.
   We may use and disclose your PHI for the following reasons:

   3.1.1. For treatment. We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.

   3.1.2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

   3.1.3. For health care operations. We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, and consultants who perform services on our behalf.

   3.2. Other Uses and Disclosures That Do Not Require Your Authorization

   3.2.1. When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.

   3.2.2. For public health activities. For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

   3.2.3. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

   3.2.4. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

   3.2.5. For research purposes. In certain circumstances, we may provide PHI in order to conduct research.

   3.2.6. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

   3.2.7. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

   3.2.8. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

   3.2.9. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders through the mail, telephone, email or by text or give you information about treatment alternatives, or other health care services or benefits we offer.

   3.2.10. Fundraising activities. We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

   3.3. Uses and Disclosures to Which You Have an Opportunity to Object

   3.3.1. Patient directories. We may include your name, location in this facility, general condition in our patient directory and disclose it to visitors who ask for you by name, unless you object in whole or in part. We also may include your religious affiliation (if any) in the facility directory and disclose facility directory information to clergy members, unless you object in whole or part.

   3.3.2. Disclosure to family, friends, or others. We may provide your PHI to a family member, friend or other person to the extent that person is involved in your care or the payment for your health care, unless you object in whole or in part.

   3.3.3. Special Legal Restrictions Frequently, Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

   3.4. All Other Uses and Disclosures Require Your Prior Written Authorization
   In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

4.1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. However, if you pay in full out-of-pocket and you request that we not disclose any information to your health plan about that service, we must grant that request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make related to your treatment.

4.2. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

4.3. The Right to See and Get Copies of Your PHI. In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
If you request copies of your PHI, we will charge you a reasonable copying fee.

4.4. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures for treatment, payment and health care operation and some other purposes per the law. The list also will not include any uses or disclosures made before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $25 for each additional request.

4.5. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not required to be disclosed to you, or (iv) not part of your medical record. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

4.6. Notice by E-Mail. If you agree to receive this notice via e-mail, you still have the right to request a paper copy of this notice.

4.7. Psychotherapy Notes. We must obtain your written authorization before we may use or disclose your psychotherapy notes, except for:
use by the originator of the psychotherapy notes for treatment; use or disclosure by Covered Entity for its own mental health training programs; or use or disclosure by Covered Entity to defend itself in a legal action or other proceeding brought by the individual.

4.8. Marketing. We must obtain your written authorization before we may use or disclose your PHI for marketing purposes, except for face-to face communications made by us to you or a promotional gift of nominal value provided by us to you.

4.9. Sale of PHI. We must obtain your written authorization before we sell your PHI.

4.10. Breach of PHI. We are required to notify you in the event of a breach of your unsecured PHI.

5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **Ascension Michigan HIPAA Privacy Office** - (See section 7 of this Notice.)
You also may send a written complaint to: Secretary of the Department of Health and Human Services
We will take no retaliatory action against you if you file a complaint.

6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments, units, contracted providers who provide services at our locations and joint ventures of the following entities:

Ascension Michigan	Ascension Providence Foundation
Ascension Brighton Center for Recovery	Ascension St. John Foundation
Ascension Crittenton Hospital	Ascension Michigan Occupational Health Partners
Ascension Eastwood Behavioral Health	Ascension SE Michigan Community Health
Ascension Medical Group	St. John Providence Partners in Care
Ascension Providence Hospital	Affiliated Health Services, Inc
Ascension St. John Hospital	Ascension Physician Services
Ascension Macomb-Oakland Hospital	Bone & Joint Surgery Center of Novi
Ascension River District Hospital	Ascension Michigan Open MRI

Also, these entities, sites and locations may share medical information with physicians and other healthcare professionals within Ascension Michigan and as a Member of a Regional Health Information Organization ("RHIO") or other Health Information Exchange ("HIE"). If you want to "opt out" of the RHIO or HIE, please notify the Privacy Officer listed under Section 7.

7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the HIPAA Privacy Officer at 248-849-5302. All complaints must be submitted in writing to:

Ascension Michigan - HIPAA Privacy Officer
28000 Dequindre Road
Warren, MI 48092

8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003. REVISED: December 1, 2016

DISCRIMINATION IS AGAINST THE LAW!

Ascension Michigan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Ascension Michigan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Ascension Michigan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats and other formats).

Ascension Michigan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, you may contact (586) 753-1888 or the Section 1557 Coordinators listed below.

If you believe that Ascension Michigan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the Ascension Michigan 1557 Coordinators:

Ascension SE Michigan Ascension Providence Hospital Ascension St. John Hospital Ascension Macomb-Oakland Hospital Ascension River District Hospital Ascension Medical Group	**Lisa Ward** **Ascension SE Michigan Director** **Clinical Safety Risk Management, Patient Relations & Recipient Rights** 16001 W. 9 Mile Rd. Southfield, MI 48075 Ascension Michigan 1557 Coordinator Line: (248) 849-2500 TTY: (313) 343-3126 Fax: (248) 849-5858 E-mail: lisa.ward3@ascension.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the 1557 Coordinators are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

1-800-368-1019; 1-200-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Ascension