

## Services Offered by Grace Health

- Behavioral Health
- Dental
- Family Practice
- Health Education
- Internal Medicine
- OB/GYN
- Optometry/ Vision Care
- Pediatrics
- Pharmacy
- Physical Therapy
- Podiatry

## Patient Advocates

Our Advocates provide assistance with community services such as food, transportation, prescription assistance, and other basic needs.

## “Ask a Nurse”

Grace Health has nurses available 24 hours a day to talk with you. The nurses can give you advice about how to take care of yourself at home, or if you need an appointment or need to be seen in the Emergency Room. The nurse can also communicate with your provider about your concerns.

## Lab

On-site lab services are provided by Bronson Laboratory at our Battle Creek location.

## Interpreters

Language interpretation and American Sign Language services are available upon request.

## School-Based Health Services

### Student Health Centers

- Springfield Middle School
- Lakeview High School
- Battle Creek Central High School

### School Wellness Programs

- Northwestern Middle School
- W.K. Preparatory High School

### Behavioral Health (only)

- Dunlap Elementary
- Purdy Elementary
- North Pennfield Elementary
- Homer Schools

## Mission Statement

*To provide patient-centered healthcare with excellence in quality, service and access*

**Your health care is important to us. Call if you are unable to keep your appointment.**

## How to Contact Us

|                                   |                |
|-----------------------------------|----------------|
| Main Number                       | (269) 965-8866 |
| Administration                    | (269) 966-2600 |
| Behavioral Health                 | (269) 441-1960 |
| Bronson Laboratory                | (269) 441-3477 |
| Dental                            | (269) 966-2625 |
| Family Practice/Internal Medicine | (269) 965-8866 |
| OB/GYN                            | (269) 965-8866 |
| Optometry / Vision Care           | (269) 441-6812 |
| Outreach & Enrollment             | (269) 441-1966 |
| Patient Accounts                  | (269) 441-3456 |
| Pediatrics                        | (269) 965-8866 |
| Pharmacy                          | (269) 441-6774 |
| Physical Therapy                  | (269) 441-6812 |
| Podiatry                          | (269) 441-6812 |

### **Fax Numbers:**

|                    |                |
|--------------------|----------------|
| Administration     | (269) 965-4773 |
| Health Information | (269) 966-2627 |
| Pharmacy           | (269) 441-6775 |

### **Albion Dental**

|        |                |
|--------|----------------|
| Phone: | (517) 629-6540 |
| Fax:   | (517) 629-6589 |

**After 5 p.m.,** please call (269) 965-8866 for after-hours emergency instructions or to speak with a nurse.

For additional information please visit our website at:

**[www.gracehealthmi.org](http://www.gracehealthmi.org)**



**Partnering  
with You  
in Your  
Health Care**

**181 West Emmett Street  
Battle Creek, MI 49037  
269-965-8866**

**115 Market Place  
Albion, MI 49224  
517-629-6540**

## Insurance / Payment Policy

Grace Health accepts Medicaid and most insurance plans.

We believe it is our responsibility to clearly communicate what we expect in our financial relationship with you. We will be glad to answer any questions you may have about the following guidelines.

- Grace Health requests payment (or an arrangement to pay) at the time of service for deductibles, co-payments, and as allowed by contract, non-covered services.
- Payment may be made by cash, check, money order, VISA, MasterCard or Discover.
- If you have made arrangements to pay in installments, we expect that you will make payments in a timely manner.
- We participate with many insurances. A Patient Accounts Representative will answer any questions you may have about Grace Health's participation in managed care or other health care plans.
- We will file your insurance claim(s) at no cost to you for any covered service. If we do not receive an insurance payment in 30-45 days, we may bill you directly.
- We expect you to present your Medicaid card at each visit as required by the Medical Assistance Program.
- If you need financial assistance, Grace Health has a Sliding Fee Discount Program through a grant from the Public Health Service.
- Failure to pay your portion of your bill in a timely manner, without prior arrangements, may result in you and your family not being allowed to be patients at Grace Health any longer.

To speak with a patient accounts representative regarding discounts and billing inquiries, call 269-441-3456

## Medical Records

All health information is strictly confidential and will not be released without your written permission. Copies of records for other healthcare providers/facilities will be provided free of charge. There is a fee for copies made for your personal records.

## A Patient-Provider Partnership

At Grace Health, patient care is given in a team-based setting. Your Primary Care Provider (PCP) works with other providers and medical staff who also know your medical history. Each team makes up a "Neighborhood", and we want you to be seen in your Grace Health Neighborhood whenever you need healthcare.

Call us first with all health-related problems unless you have a true medical emergency. If you have a medical emergency, call 911 or go to the nearest emergency room.

## Our Role in Your Care

- Treat you as a partner in your care.
- Be available and timely with our care and information to you.
- Get to know you, your family, your life situation, and your preferences.
- Suggest care, treatments and goals that make sense for you.
- Answer your questions in a way that you understand.
- Connect you to resources that help you achieve better health.
- Communicate your plan of care with your healthcare team.

## Your Role in Your Care

- Know that you are a partner in your care.
- Make appointments with your PCP and be on time.
- Learn about your health/health conditions.
- Share information about all medications and treatments received elsewhere.
- Work with your PCP to identify and monitor treatment and self-care goals.
- Help make decisions about your care.
- Join in activities to reduce health risks.
- Follow the health plan that you and your PCP have agreed on.
- Ask questions until you understand!



For your privacy and the privacy of others, cell phone use is prohibited in clinical areas.

## Hours

### Family Practice, Internal Medicine

|                 |   |
|-----------------|---|
| Monday – Friday | 7:00 a.m. – 8:00 p.m.                           |
| Walk-In Hours   | 8:00 a.m. – 12:00 p.m.<br>4:00 p.m. – 7:00 p.m. |

### Pediatrics

|                 |                        |
|-----------------|------------------------|
| Monday – Friday | 8:00 a.m. – 5:00 p.m.  |
| Walk-in Hours   | 8:00 a.m. – 12:00 p.m. |

### OB/GYN

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 8:00 a.m. – 5:00 p.m. |
|-----------------|-----------------------|

### Behavioral Health

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 8:00 a.m. – 5:00 p.m. |
|-----------------|-----------------------|

### Dental

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 7:00 a.m. – 6:00 p.m. |
| Walk-In Hours   | 7:00 a.m. – 5:00 p.m. |

### Optometry / Vision Care

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 8:00 a.m. – 5:00 p.m. |
|-----------------|-----------------------|

### Pharmacy

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 8:00 a.m. – 7:00 p.m. |
|-----------------|-----------------------|

### Physical Therapy

|                     |                        |
|---------------------|------------------------|
| Monday & Thursday   | 8:00 a.m. – 6:00 p.m.  |
| Tuesday & Wednesday | 8:00 a.m. – 5:00 p.m.  |
| Friday              | 8:00 a.m. – 12:00 p.m. |

### Podiatry

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 8:00 a.m. – 5:00 p.m. |
|-----------------|-----------------------|

### Albion Dental

|                 |                       |
|-----------------|-----------------------|
| Monday – Friday | 7:00 a.m. – 5:30 p.m. |
|-----------------|-----------------------|

Grace Health will open at 9:00 a.m. on the first Friday of every month.

## Appointments

Please let the receptionist know the name of the provider you wish to see. We will make every effort to accommodate your request and can often see you the same day.

Please bring the following items with you to every appointment:

- Photo ID
- insurance or Medicaid card
- Bottles of all current prescription medications, vitamins, supplements and any other over-the-counter pills you currently take.

**Your health care is important to us. Call if you are unable to keep your appointment.**

## *Patient Rights*

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- ❖ You have the right to access care regardless of race, color, creed, sex/gender identity, sexual orientation, national origin, religion, disability or source of payment, unless restricted by contract.
- ❖ You have the right to receive considerate, respectful care with recognition of your personal dignity.
- ❖ Information about your care will be treated as confidential. Information will not be released to anyone without your approval, except if required or allowed by law.
- ❖ You have the right to expect reasonable safety and privacy where Grace Health practices and environment are concerned.
- ❖ You have the right to request accommodations for a disability.
- ❖ You have the right to receive language or American Sign Language (ASL) interpretation.
- ❖ You have the right to have your questions answered about Grace Health rules and regulations regarding patient care.
- ❖ You have the right to know the identity of anyone providing a service to you.
- ❖ You have the right to know which healthcare provider is primarily responsible for your care (your primary care provider or PCP).
- ❖ You have the right to have information explained to you so you can understand it and to have all your questions answered.
- ❖ You have the right to make decisions about the plan of care that is recommended by your provider. You have the right to accept or refuse care or recommended treatment to the extent permitted by law.
- ❖ You have the right to discuss the benefits, risks and costs of all treatment options and receive advice from your provider about the best course of action.
- ❖ You have the right to have your pain assessed and managed to the greatest extent possible and to participate in planning your pain management.
- ❖ You have the right to expect that Grace Health will provide you with necessary health services to the best of its ability. If care is required which isn't available at Grace Health, referral or transfer may be recommended for you.
- ❖ You have the right to review your medical record and have the information explained, except when restricted by law. You have the right to receive a copy of your record.
- ❖ We value your feedback. You have the right to voice your concerns without fear of discrimination. If you would like more information about our complaint process or to share a compliment about our services, please contact any Grace Health employee.
- ❖ You have the right to see a copy of your bill and have the bill explained to you. You have the right to receive a copy of your bill, except when prohibited by state or federal regulations.
- ❖ You have the right to information about financial assistance.

*Please call (269) 965-8866 to let us know if you have any comments, questions or concerns about care at Grace Health.*

## *Patient Responsibilities*

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- ❖ You are responsible for calling us first with all health-related problems, unless it is a medical emergency (in that case, go to the nearest emergency room.)
  - ❖ You are responsible for keeping appointments. If you cannot keep your appointment, it is your responsibility to call and cancel the appointment with as much notice as possible.
  - ❖ You are responsible for providing accurate and complete information about your medical problem(s), current medications and past medical history.
  - ❖ You are responsible for reporting to your healthcare provider any unexpected changes in your health or care received by a specialist or other healthcare facility.
  - ❖ You are responsible for telling us if you do not understand your treatment plan or what is expected of you.
  - ❖ You are responsible for being truthful and to express your concerns clearly to your healthcare provider.

- ❖ You are responsible to help your provider plan your care and to tell your provider if you cannot follow through with your plan of care.
- ❖ You are responsible for providing correct and timely insurance information to Grace Health staff. It is your responsibility to pay your part of the bill as fast as possible.
- ❖ You are responsible for following Grace Health rules that affect patient care and conduct.
- ❖ You are responsible for being considerate of the rights of other patients, visitors, and staff, including not using foul, abusive, or threatening language or behavior.
- ❖ You are responsible for being respectful of the property of other patients, visitors, staff, and Grace Health property.
- ❖ Failing to comply with any of these responsibilities may result in you and your family (or household members) not being seen as patients at Grace Health any longer.

## ***Patient Rights and Responsibilities***



181 West Emmett Street  
Battle Creek, MI 49037-2963  
(269) 965-8866

115 Market Place  
Albion, MI 49224-1767  
(517) 629-6540

We create a record of all the medical, pharmacy or dental services that you receive at Grace Health. This record contains information about your symptoms, examinations, test results, x-rays, diagnoses, treatment, our plan for future care and the services we have provided.

At Grace Health, we respect our patients and their personal information. We are committed to protecting the privacy of our patient records. We are also required by state and federal laws to maintain the privacy of protected health information.

One of the requirements of the federal Privacy Rules is to provide patients with a Notice of Privacy Practices. This notice tells how we may use your patient information and how it may be disclosed to others. It also explains your rights and some of our legal obligations regarding your health records.

### **Uses and disclosures of health information**

Grace Health employees may use or disclose your patient information to provide treatment, obtain payment and carry out health care operations.

Treatment: Your patient information is used by the people taking care of you at our office. We may also share information with others who are helping us provide treatment for you, such as a medical specialist, hospital, laboratory or pharmacy.

Payment: Your patient information may be used as we bill and collect payment for the treatment and services you receive. We may contact your insurance company to verify coverage, and we may share the information with them to obtain payment for services we have provided or to request authorization for treatment. Information may be disclosed to our collection agency in case of non-payment for services.

Operations: We may use your health information as we operate and manage our practice and to make sure that you and our other patients receive

quality care. This includes using patient information to evaluate the performance of our staff, to find ways to become more efficient and to decide what services to offer. When information is shared with others who provide business services for our organization, they are also required to protect the privacy of our patient information.

Appointment reminders and leaving messages: We may contact you or leave a message on an answering machine or with a household member to remind you of your appointment. We may also leave messages about the status of services we are providing for you or to request return calls to our office.

Text messaging: If you share your cell phone number with us, appointment reminders and payment alerts may be sent in text messages. We may also send you information about tests, appointments, and other procedures for which you are due. Text messaging is optional, so you may opt out at any time.

Other electronic communication: We may securely send or receive messages through the Patient Portal. We do not use email to communicate with individual patients or receive messages from them.

Treatment alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Fundraising: Some patients may receive letters requesting donations to Grace Health. If you do not want to be on that mailing list, you may contact us by phone or mail.

Emergency situations: In the case of a medical emergency, your information may be disclosed without obtaining a signed authorization to prevent delays in treatment. We may not be able to honor any normal restrictions on use or disclosure if emergency treatment is required. We may notify your family members, caregivers, and/or close friends in case of a medical emergency or if you are incapacitated. We may also share information that relates to their involvement in your health care based on our

professional judgment if we determine it is in your best interest.

Disclosures permitted by law: We may disclose information about you without your permission if permitted or required by law. This includes the following situations:

- Immunization records – Immunization records will be reported to the Michigan Care Improvement Registry (MCIR).
- Public health authorities – We will disclose information to your county health department if you have one of the communicable diseases that must be reported under Michigan law. Information may be reported to state or federal agencies regarding preventing or controlling disease, workplace injuries and adverse events related to food or medical products.
- Controlled substance reports – If our pharmacy dispenses a controlled substance, we will report all details of the prescription and your government-issued ID to the State of Michigan.
- Court order – We will release any information requested in a court order or a subpoena issued by an official of the courts.
- Minor's confidential information – If you are a minor seeking your own care as allowed by law, we may contact your parents with information about your condition if it is determined medically necessary by a health care provider. Your parents may also become aware of the treatment if they are responsible for payment for the services.
- Abuse or neglect – We will report cases of suspected abuse or neglect to Child Protective Services or Adult Protective Services as required by law.
- Domestic abuse – We will report cases of domestic abuse to the authorities as required by law.
- Law enforcement – We may release information to law enforcement as needed to avert a serious health or safety threat or to locate a suspect, fugitive, material witness or missing person. We may release information to law enforcement for investigation of illegal activities involving controlled substances.

- Dental records – Dental records may be released to law enforcement to identify a deceased or missing person.
- Deceased patients – Information about deceased patients may be disclosed to the medical examiner, funeral director or an institutional review board such as the Fetal Infant Mortality Review.

Integrated Health Partners (IHP): We are a member of this hospital physician organization whose activities include medical insurance support, quality improvement and a community collaborative for chronic disease and case management. Your information may be shared with the IHP staff and partnering providers for those purposes.

Health Information Exchange: Other healthcare organizations providing care for you and clinical record extract services providing information to your insurance company may be able to view your health records electronically. Contact our Privacy Officer if you wish to opt out from this electronic exchange.

Video Recording: With your signed consent, your medical appointment with a resident may be recorded for educational purposes.

Other uses and disclosures: We will obtain written authorization from you or your legal representative for any uses or disclosures that are not described above, are not permitted by law or are not related to treatment, payment or health care operations. You may revoke a previously made authorization by providing written notice.

Notification of breaches: We will make every effort to protect the privacy of your health information. We will notify you by mail about a breach of confidentiality.

### **Patient rights**

You have the following rights regarding your medical or dental records:

- Right to request restrictions on uses or disclosures – You have the right to request that we place limitations on our use or disclosure of

your patient information. We have the right to choose not to agree to the requested restriction.

- Right to receive confidential communications – You have the right to request that we use alternative methods to contact you. We have the right to choose not to agree to the request.
- Right to inspect and copy – You have the right to make an appointment to review your health records. You may also request to receive a copy of your records at a reasonable fee. You may request that the records be provided in electronic format.
- Right to amend – You have the right to add a written statement to your records to clarify or correct the information within your chart.
- Right to receive an accounting of disclosures – You have the right to request a list of all disclosures made without your written authorization that were not made for the purposes of treatment, payment or health care operations.
- Right to restrict disclosures to health plan – If you pay in full for services, you can request that information about those visits is not provided to your health insurance plan.

### **Changes to this notice**

We reserve the right to revise this notice when there has been a material change in our privacy practices. We will abide by the terms of the notice currently in effect. The current version of the notice will be posted at Grace Health and on our website at [www.gracehealthmi.org](http://www.gracehealthmi.org). You may contact us to receive a written copy.

### **Questions or complaints**

If you have questions about this notice or Grace Health's privacy practices, please contact our Privacy Officer at (269) 965-8866. If you believe your privacy rights have been violated, you may contact our Privacy Officer. You may also file a written complaint with the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

# **Notice of Privacy Practices**

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

*Effective: April 14, 2003*

*Revised: July 1, 2019*

**Grace Health**  
181 West Emmett Street  
Battle Creek, MI 49037-2963  
(269) 965-8866

**Albion Office**  
115 Market Place  
Albion, MI 49224  
(517) 629-6540



Grace Health

## **Acknowledgment of Receipt of Notice of Privacy Practices**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient/Parent/Guardian/Representative

\_\_\_\_\_  
Date

### **For Grace Health Use Only:**

The Notice of Privacy Practices was presented to the patient today. The patient or representative declined to sign this Acknowledgment of Receipt of Notice of Privacy Practices upon request.

\_\_\_\_\_  
Grace Health employee

\_\_\_\_\_  
Date



**Medical Care Authorization**Patient Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(please print)Preferred Name \_\_\_\_\_ Parent/Legal Guardian \_\_\_\_\_  
(please print) (please print)

I hereby authorize Grace Health to give me reasonable and proper medical/dental care by today's standards. I authorize direct payment of insurance benefits to Grace Health, realizing I am responsible for any unpaid balance. I authorize the release of medical information to the Centers for Medicare & Medicaid Services and its agents and to my insurance company for billing purposes and to other health care providers for continued treatment, understanding that this may include records of treatment for drug and/or alcohol dependency or abuse; mental health treatment; or testing, care, treatment or reporting pertaining to infection with HIV or related diseases.

\_\_\_\_\_  
(Signature of Patient / Parent/Legal Guardian) (Date)**Authorization for Verbal  
Disclosure of Medical Information**

I authorize Grace Health to disclose and discuss medical information with the following person(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Authorization for Written  
Disclosure of Medical Information**

I authorize Grace Health to disclose written medical information with the following person(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand the information being disclosed may include medications, test results and treatment plan, including treatment for mental health, substance dependency or abuse and testing or treatment for HIV or AIDS. Once the information is disclosed, it is not protected under federal privacy rules, so there is a possibility it may be redisclosed by the person receiving the information.

\_\_\_\_\_  
Patient/Legal Representative ☐ Parent ☐ Guardian ☐ \_\_\_\_\_\_\_\_\_\_  
Witnessed By\_\_\_\_\_  
(Date)\_\_\_\_\_  
(Date)



**- Pediatric Demographics -**

Date \_\_\_\_\_

|  |   |                                 |  |                                 |   |                                 |
|--|---|---------------------------------|--|---------------------------------|---|---------------------------------|
| Patient's Last Name  |   | First                           | Middle Initial   | Date of Birth                   | Sex                                       | Social Security Number          |
| Street Address   |   |                                 | City   | State / Zip Code                |   |                                 |
| Home Telephone Number<br>( )   |   | Cell Phone No. for<br>( )       |  | Message Telephone Number<br>( ) |   |                                 |
| Parent/Guardian  |   |                                 | Parent/Guardian  |                                 |   |                                 |
| Relationship<br><input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian |   |                                 | Relationship<br><input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian |                                 |   |                                 |
| Parent's Date of Birth   |   | Parent's Social Security Number |  | Parent's Date of Birth          |   | Parent's Social Security Number |
| Parent's Address (if different from patients)  |   |                                 | Parent's Address (if different from patients)  |                                 |   |                                 |
| Parent's Employer  |   |                                 | Parent's Employer  |                                 |   |                                 |
| Parent's Work Phone Number   |   |                                 | Parent's Work Phone Number   |                                 |   |                                 |
| Parent's Email Address   |   |                                 | Parent's Email Address   |                                 |   |                                 |
| Local Contact for Emergencies  |   |                                 | Relationship to Patient  |                                 | Emergency Contact Telephone Number<br>( ) |                                 |
| Race   | May Choose More than One. Circle Top Choice.<br><input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Choose not to disclose<br><input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other _____ |                                 |  |                                 |   |                                 |
| Ethnicity  | May Choose More than One. Circle Top Choice.<br><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino<br><input type="checkbox"/> Unreported/Choose not to disclose   |                                 |  |                                 |   |                                 |
| Language   | <input type="checkbox"/> English <input type="checkbox"/> Spanish<br><input type="checkbox"/> Burmese <input type="checkbox"/> Other _____  |                                 |  |                                 |   |                                 |
| Do you need help finding a place to live? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                 |  |                                 |   |                                 |

**Insurance Information ☐ No Insurance Coverage**

|                                   |                     |  |                            |                                     |  |
|-----------------------------------|---------------------|--|----------------------------|-------------------------------------|--|
| <input type="checkbox"/> Medicaid | Medicaid Number     |  |                            |                                     |  |
| <input type="checkbox"/> Other    | Insurance Name      | Group Number   | Policy Number              |                                     |  |
|                                   | Subscriber/Employee | Patient is:<br><input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent | Subscriber's Date of Birth | Subscriber's Social Security Number |  |
| <input type="checkbox"/> Other    | Insurance Name      | Group Number   | Policy Number              |                                     |  |
|                                   | Subscriber/Employee | Patient is:<br><input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent | Subscriber's Date of Birth | Subscriber's Social Security Number |  |

|   |   |
|---|---|
| <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Grace Health offers discounted fees to those who qualify. If you would like information about our Schedule of Discounts Program, please mark "Yes". |
|---|---|

**Reporting yearly household size and income is a government requirement that will allow Grace Health to continue to receive funding to provide special services for our patients. Please support these programs by providing the following information:**

Number of people living in home: \_\_\_\_\_ Total household income: \_\_\_\_\_ Choose not to disclose: \_\_\_\_\_

Grace Health  
**Pediatric History**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

**Child's Birth History**

- ☐ Full term    ☐ Premature (how many weeks?) \_\_\_\_\_  
☐ Vaginal delivery    ☐ C-section (why?) \_\_\_\_\_  
                                    ☐ Vacuum assisted    ☐ Forceps assisted

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_

Any problems with pregnancy, labor or delivery? (please list) \_\_\_\_\_

How many days was the baby in the hospital? \_\_\_\_\_

Any medical problems in the nursery? (oxygen, antibiotics, jaundice, etc.) \_\_\_\_\_

**Surgeries/Operations**

| <u>Type</u> | <u>When</u> | <u>Where</u> |
|-------------|-------------|--------------|
| _____       | _____       | _____        |

**Hospitalizations**

| <u>Type</u> | <u>When</u> | <u>Where</u> |
|-------------|-------------|--------------|
| _____       | _____       | _____        |

**Medications** (If you don't know the name, please indicate why the child takes the medication)

\_\_\_\_\_

**Allergies**

To medications \_\_\_\_\_

Other (foods, etc.) \_\_\_\_\_

**Immunizations** (Please have your child's immunization card available for our review)

Are the child's immunizations (shots) up to date? ..... ☐ Yes    ☐ No

If no, when was the child's last set of shots? \_\_\_\_\_

Were the shots given in the state of Michigan? ..... ☐ Yes    ☐ No

Has the child had chicken pox? ..... ☐ Yes    ☐ No

or received the chicken pox shot? ..... ☐ Yes    ☐ No

Has the child completed the series of three Hepatitis B shots? ..... ☐ Yes    ☐ No

**Social History**

Who lives with the child? \_\_\_\_\_

Any pets?    ☐ Yes    ☐ No    If yes, what types? \_\_\_\_\_

Does anyone smoke? (include smoking outside the house)    ☐ Yes    ☐ No

Does the child attend daycare?    ☐ Yes    ☐ No

If yes, please check type of daycare:

☐ in home daycare    ☐ a relative's home    ☐ large childcare center

Are there any guns in the home?    ☐ Yes    ☐ No

What grade is the child in? \_\_\_\_\_ What school? \_\_\_\_\_

**Child's Health History** (Please check if the child has ever had these problems and explain)

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Skin (e.g. eczema, hives, rashes) .....                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Head (e.g. headaches, migraines) .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eye (e.g. wears glasses).....                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ears (e.g. frequent infections) .....                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dental (e.g. baby bottle tooth decay) .....                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid or gland .....                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart (e.g. murmur, high blood pressure) .....               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung (e.g. asthma, chronic cough, cystic fibrosis) .....     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stomach/bowel (e.g. constipation, chronic diarrhea) .....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urinary (e.g. bedwetting, daytime wetting, UTI).....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood (e.g. abnormal bleeding or clotting, sickle cell)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle (e.g. weakness) .....                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bone or joint (e.g. broken bones, arthritis) .....           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nervous system (e.g. seizures).....                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Behavior/mental health (e.g. ADHD, depression).....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abuse (e.g. physical, emotional, sexual) .....               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered "yes" to any of the above questions, please explain below:

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**Family History** (Does a family member have any of these medical problems?)

|                              |                                 |                                 |                                  |                                 |                                      |
|------------------------------|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------------|
| Asthma (chronic cough) ..... | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |
| Diabetes .....               | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |
| Heart Disease .....          | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |
| High Cholesterol .....       | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |
| Cancer .....                 | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |

List type of cancer \_\_\_\_\_

|                           |                                 |                                 |                                  |                                 |                                      |
|---------------------------|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------------|
| High Blood Pressure ..... | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |
| Mental Health.....        | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |

List type \_\_\_\_\_

|             |                                 |                                 |                                  |                                 |                                      |
|-------------|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------------|
| Abuse ..... | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent |
|-------------|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------------|

List type (e.g. physical, emotional, sexual) \_\_\_\_\_

Other (please explain) \_\_\_\_\_

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## Consent for Treatment

**Please plan to come to each visit with your child/legal ward.** We can give better care and answer your questions when we talk with you directly about your child/legal ward.

If you are not able to come to the appointment, make sure the adult listed on this form knows about your child/legal ward and will tell you what happened at the visit.

Please complete the following information for our records.

I, \_\_\_\_\_, give my permission for  
Name of parent or legal guardian

\_\_\_\_\_, Or \_\_\_\_\_  
Name of friend/relative Name of friend/relative

or \_\_\_\_\_, or \_\_\_\_\_  
Name of friend/relative Name of friend/relative

to seek medical care for my child/legal ward listed below. This includes but is not limited to obtaining prescriptions and consenting for immunizations, medicines and procedures.

\_\_\_\_\_  
Name of child/legal ward Date of birth

\_\_\_\_\_  
(initials) I also authorize Grace Health to reveal and discuss all medical information

about my child/legal ward to the above-named persons.

This consent is effective as of today until rescinded or changed by me.

\_\_\_\_\_  
Signature of parent or legal guardian Date

\_\_\_\_\_  
Witness Date

## Autorización para Tratamiento

**Por favor, planifique asistir con su niño/pupilo a cada visita.** Podemos proveer mejor cuidado y contestar sus preguntas cuando hablamos con usted directamente acerca de su niño/pupilo.

En el caso de que usted no pueda asistir a una cita, asegúrese que el adulto nombrado en esta forma sepa todos los datos de su niño/pupilo y que le informará a usted lo que ha sucedido en la cita.

Por favor complete la siguiente información para nuestros registros.

Yo, \_\_\_\_\_, doy mi autorización para que  
Nombre del padre o guardián legal

\_\_\_\_\_, O \_\_\_\_\_,  
Nombre de amigo/familiar Nombre de amigo/familiar

O \_\_\_\_\_, O \_\_\_\_\_,  
Nombre de amigo/familiar Nombre de amigo/familiar

que busque cuidado médico para mi hijo/pupilo mencionado a continuación. Esto incluye, pero no está limitado a obtener recetas médicas y autorización para vacunas, medicamentos y procedimientos.

\_\_\_\_\_  
Nombre del niño/pupilo Fecha de nacimiento

\_\_\_\_\_  
(iniciales) También autorizo a Grace Health a revelar y discutir toda información

médica acerca de mi niño/pupilo a las personas mencionadas anteriormente.

Este permiso es efectivo de hoy en adelante hasta que yo lo cancele o haga algún cambio.

\_\_\_\_\_  
Firma del padre o guardián legal Fecha

\_\_\_\_\_  
Testigo Fecha

Grace Health

**Patient Eligibility Screening Record  
Vaccines for Children Program**

Child \_\_\_\_\_ Date \_\_\_\_\_  
Last Name First Name MI

Date of Birth \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
Last Name First Name MI

This child qualifies for vaccination through the VFC program because he/she:

**[check only one box]**

- ☐ is enrolled in Medicaid
- ☐ does not have health insurance
- ☐ is American Indian or Alaskan Native
- ☐ has health insurance that does not pay for vaccines

This child does not qualify for vaccination through the VFC program because he/she:

- ☐ has health insurance that pays for vaccines



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## **Call Us First 24/7**

*We can help you decide whether to be seen at Grace Health, at the Emergency Room or Urgent Care*

Nurses are available 24 hours a day, 7 days a week

**Call (269) 965-8866**

### **Family, Internal and Pediatric Medicine**

Hours: Monday - Friday 7:00 am - 8:00 pm

**Walk-in hours:** 8:00 am - 12:00 pm and 4:00 pm - 7:00 pm

Appointments such as: sore throat • ear pain • fever • sprain

**Call (269) 965-8866**

### **Dental**

Hours: Monday - Friday 7:00 am - 6:00 pm

**Walk-in hours:** 7:00 am – 5:00 pm

Appointments such as: tooth pain • simple fillings and extractions

**Call (269) 966-2625**

### **Specialty Services by Appointment**

Physical Therapy

Podiatry

Optical

**Call (269) 441-6812**

### **OB/GYN**

Hours: Monday - Friday 8:00 am - 5:00 pm

**Call (269) 965-8866**

Free pregnancy tests 8:00 am - 4:30 pm

### **Behavioral Health**

Hours: Monday - Friday 8:00 am - 5:00 pm

**Call (269) 441-1960**



## Student Health Centers

|                            |                |
|----------------------------|----------------|
| Lakeview High School       | (269) 565-3704 |
| Springfield Middle School  | (269) 441-1295 |
| Battle Creek Central       | (269) 965-9539 |
| WK Preparatory High School | (269) 965-9676 |
| Northwestern Middle School | (269) 965-9662 |

## Grace Health Pharmacy

Hours: Monday - Friday 8:00 am - 7:00 pm

Accepting prescriptions written by any provider

We can help transfer your prescription

**Call (269) 441-6774**

## Patient Portal

**Securely** access your information 24/7 on your computer or mobile device to:



- **View lab results**
- **Request medication refills**
- **Pay your bill**
- **Request an appointment**
- **Ask a question**



Sign up today at [www.gracehealthmi.org](http://www.gracehealthmi.org)  
and click on the Patient Portal

## Questions?

**Contact us at (269) 965-8866**

Grace Health is your medical home.  
Our goal is to partner with you to meet your health care needs.



181 West Emmett Street, Battle Creek, MI 49037

**EFFECTIVE JANUARY 1, 2018**

## **Missed Appointments**

Our goal is to provide patients with an appointment when they need it. When a patient does not keep an appointment (or “no-shows”), it takes away from another person who needs to be seen. **Patients who no-show 3 appointments in a 12-month period will not be able to schedule appointments in advance.**

Grace Health has a new policy to provide patients with access to health care in ways that work for them.

### **APPOINTMENT OPTIONS:**

Advanced scheduling is available if you have not missed 3 appointments in a 12-month period.

- After 6-months, if you have kept all your scheduled same-day appointments, you may again schedule in advance.

Same-day appointments with your primary care provider (PCP), if possible, or with another provider in your PCP's neighborhood.

Walk-in appointments during scheduled walk-in hours.

We understand there are reasons that may keep you from coming to your appointment. If you are unable to make your appointment:

- **Call us.** Your health care is important to us. Call if you are unable to keep your appointment.
- **We are here to help.** Tell us why you are unable to keep your appointment. We will work with you to try and find a solution.



**269-965-8866**  
**181 West Emmett St.**  
**Battle Creek, MI 49037**

***Efectivo el 1 de enero del 2018***

## Citas perdidas

Nuestro objetivo es proporcionar a los pacientes una cita cuando la necesiten. Cuando un paciente no mantiene su cita (o "no-shows"), le quita la oportunidad a otra persona que necesita ser vista. **Los pacientes que no se presenten a 3 citas en un período de 12 meses no podrán programar citas con anticipación.**

Grace Health tiene una nueva política para proporcionar a los pacientes acceso a la atención de salud en formas convenientes para ellos.

### **OPCIONES DE CITAS:**

**Programación avanzada** está disponible si no ha perdido 3 citas en un período de 12 meses.

- Después de 6 meses, si atendió a todas sus citas hechas el mismo día, usted podrá programar de nuevo citas con anticipación.

**Citas del mismo día** con su proveedor de atención primaria (PCP), si es posible, o con otro proveedor en el vecindario de su PCP.

**Citas de pacientes ambulatorios** durante las horas programadas para pacientes ambulatorios. (Sin previa cita)

Entendemos que hay razones que pueden impedir que usted llegue a su cita. Si no puede atender a su cita:

- **Llámenos.** Su atención médica es importante para nosotros. Llame si no puede mantener su cita.

**Estamos aquí para ayudarle.** Díganos por qué no puede mantener su cita. Trabajaremos con usted para intentar encontrar una solución.



**269-965-8866  
181 West Emmett St.  
Battle Creek, MI 49037**