

## Services Offered by Grace Health

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

## Community Health Workers/Resource Specialists

Our Community Health Workers and Resource Specialists help patients connect to local resources and navigate programs for items such as food, transportation, housing, prescriptions, and other basic needs.

### “Ask a Nurse” 24/7

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 advise 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
- Verona Elementary

## 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 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 treatment 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 – Thursday 7:30 a.m. – 6:30 p.m.  
Friday 8:00 a.m. – 5:00 p.m.

### Pediatrics

Monday – Thursday 7:30 a.m. – 6:30 p.m.  
Friday 8:00 a.m. – 5:00 p.m.

### OB/GYN

Monday – Friday 8:00 a.m. – 5:00 p.m.

### Behavioral Health

Monday – Thursday 8:00 a.m. – 6:30 p.m.  
Friday 8:00 a.m. – 5:00 p.m.

### Dental

Monday – Thursday 7:30 a.m. – 6:30 p.m.  
Friday 8:00 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. – 5:30 p.m.  
Tuesday & Wednesday 8:00 a.m. – 5:00 p.m.  
Friday 8:00 a.m. – 12:00 p.m.

### Podiatry

Thursday 1:00 pm. – 5:00 p.m.

### Albion Dental

Monday – Friday 8:00 a.m. – 5:00 p.m.

Grace Health will open at 9:00 a.m. on the first Friday of the following months: January, March, May, July, September, and November.

## Appointments

Please let the Patient Service Assistant know the name of your PCP. 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*



- ❖ 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.

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# **Notice of Privacy Practices**

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**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.

\_\_\_\_\_  
Electronic Signature of  
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.

\_\_\_\_\_  
Electronic Signature of Grace Health Employee

\_\_\_\_\_  
Date

Grace Health

## Acknowledgment of Receipt of Notice of Privacy Practices

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

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\_\_\_\_\_  
Electronic Signature of  
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.

\_\_\_\_\_  
Electronic Signature of Grace Health Employee

\_\_\_\_\_  
Date



# Medical Care Authorization and Consent for Treatment

Patient Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(PRINT)

Preferred Name \_\_\_\_\_ Parent/Legal Guardian \_\_\_\_\_  
(PRINT) (PRINT)

*I hereby authorize Grace Health to give me reasonable and proper medical/dental care, which may include telemedicine services, 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, including psychotherapy notes; or testing, care, treatment or reporting pertaining to infection with HIV or related diseases.*

## Authorization for Disclosure of Medical Information:

I authorize Grace Health to disclose written and verbal medical information with the following person(s) as indicated below:

- \_\_\_\_\_  Verbal  Written
- \_\_\_\_\_  Verbal  Written
- \_\_\_\_\_  Verbal  Written
- \_\_\_\_\_  Verbal  Written

I do not wish to add any additional people for disclosure of my medical information.

## Consent for Treatment – Minor or Legal Ward:

I authorize the following adult (18 years or older) person(s) to seek medical care for my child or legal ward (listed as the patient above) when I am unable to do so and understand that by allowing them to seek care for the patient, this includes, but is not limited to obtaining prescriptions, consenting for immunizations, medicines and procedures, and that all medical information, verbal and written, may be revealed and discussed with them:

- \_\_\_\_\_  Verbal  Written
- \_\_\_\_\_  Verbal  Written
- \_\_\_\_\_  Verbal  Written
- \_\_\_\_\_  Verbal  Written

I do not authorize any non-legal guardian or person(s) to consent for medical treatment for the named patient.

***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  \_\_\_\_\_

\_\_\_\_\_  
(Date)

## Pediatric Demographics

Date \_\_\_\_\_

Patient's Last Name	First	Middle Initial	Date of Birth	Sex	Social Security Number
Preferred Name					
Street Address			City		State / Zip Code
Home Telephone Number ( )	Cell Phone No. for _____ ( )		Message Telephone Number ( )		
Parent/Guardian			Parent/Guardian		
Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian			Relationship <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 ( )	
Race	May Choose More than One. Circle Top Choice. <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other _____				
Ethnicity	May Choose More than One. Circle Top Choice. <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/o <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Spanish <input type="checkbox"/> Unreported/Choose not to disclose				
Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <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: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <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: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number	

- Yes
- 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:* \_\_\_\_\_

# Patient History

Name \_\_\_\_\_ Date \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_

I am a  Male  Female  
I see myself as a  Male  Female

Do you have an Advance Directive?  Yes  No  Don't Know  Want Information

### Past Medical History: (please check all that apply)

Childhood Diseases: ..  asthma ....  chicken pox.....  measles ....  meningitis ....  mumps..... rheumatic fever

Adult Illnesses: .....  asthma ....  bipolar disorder.....  bronchitis .....  cancer .....  depression/anxiety  
 diabetes ..  eczema .....  emphysema .....  glaucoma....  heart attack/failure  
 hepatitis ..  high blood pressure....  high cholesterol..  HIV .....  schizophrenia  
 seizure ....  stroke.....  TB .....  thyroid disease .....  ulcer

Other \_\_\_\_\_

### Operations

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

### Hospitalizations: (other than the above operations)

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

### Current Medications/Over-the-Counter/Vitamins/Herbs: (if you don't know the name, please indicate why you take them)

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

### Allergies

Medications \_\_\_\_\_

Other (food, latex, environmental) \_\_\_\_\_

### Health Maintenance Screening

Last Tetanus shot \_\_\_\_\_ Last Flu shot \_\_\_\_\_ Last Pneumonia shot \_\_\_\_\_

Last Mammogram \_\_\_\_\_ Colonoscopy/sigmoidoscopy \_\_\_\_\_ Stool test for blood \_\_\_\_\_

Last Cholesterol test \_\_\_\_\_ Exercise: How often \_\_\_\_\_ Type \_\_\_\_\_

Number of meals eaten per day \_\_\_\_\_ Number of dairy servings per day \_\_\_\_\_

Recent weight gain/loss \_\_\_\_\_

Do you need help with:  dressing  hygiene  eating  chores  walking  other \_\_\_\_\_?

### Family History

*Father:*  Living – age \_\_\_\_\_, health problems \_\_\_\_\_  
 Deceased – age \_\_\_\_\_ and cause of death \_\_\_\_\_

*Mother:*  Living – age \_\_\_\_\_, health problems \_\_\_\_\_  
 Deceased – age \_\_\_\_\_ and cause of death \_\_\_\_\_

*Brothers or Sisters:*  Living – age(s) \_\_\_\_\_, health problems \_\_\_\_\_  
 Deceased – age(s) \_\_\_\_\_ and cause of death \_\_\_\_\_

General Family History: (check and write which family member in relationship to you)

- Diabetes \_\_\_\_\_
- Stroke \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Cancer \_\_\_\_\_
- Mental Illness \_\_\_\_\_

Current Problems: (please check all that apply)

- Skin:*.....  hives .....  rashes
- Head:*.....  fainting .....  severe headaches
- Eye/Ear:*.....  pain.....  difficulty seeing/hearing
- Dental, lip or throat:* .....  dentures.....  difficulty swallowing
- Heart:*.....  racing.....  heart murmur .....  severe chest pains
- Lung:*.....  chronic cough ....  difficulty breathing...  cough up phlegm/blood...  abnormal chest x-ray
- Breast:*.....  lumps .....  pain .....  discharge
- Gastro-intestinal:* .....  nausea .....  constipation.....  stomach pains/bloating ...  vomited blood  
 rectal bleeding ....  loose/black stools
- Urinary:*.....  bloody urine .....  penis discharge.....  problem with erection  
 frequent/burning with urination .....  difficulty starting/leaking urine
- Blood:* .....  clotting .....  abnormal bleeding
- Muscle, Bone, Joint:* .....  pain.....  swelling
- Mental Health:* .....  nervousness .....  problem sleeping ....  hearing voices .....  seeing things  
 sadness .....  thoughts of hurting myself or someone else..  drug or alcohol abuse
- Other* \_\_\_\_\_

- Sexual: Are you in a sexual relationship?  Yes  No Partner:  Male  Female
- How long with current partner(s)? \_\_\_\_\_
- How many sex partners have you had in your life? \_\_\_\_\_
- Bleeding/Pain after sexual relations?  Yes  No
- Are you satisfied with your sex life?  Yes  No

- Female Only First day of last period \_\_\_\_\_ Cramping before or with period \_\_\_\_\_
- Days between periods \_\_\_\_\_ Length of periods \_\_\_\_\_
- Pass clots with period?  Yes  No Last pelvic exam/Pap smear \_\_\_\_\_
- Method of birth control \_\_\_\_\_ How long on birth control \_\_\_\_\_
- Itching in vaginal area?  Yes  No Unpleasant odor?  Yes  No
- Any abnormal Pap smear results?  Yes  No
- Number of: Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_
- Do you do a self-breast exam monthly?  Yes  No

- Male Only Do you do a self-testicular exam monthly?  Yes  No
- If over 40 years of age, have you had a prostate test or exam done?  Yes  No

- Social History  Married  Separated  Divorced  Widowed  Single
- Occupation \_\_\_\_\_
- Who do you live with? \_\_\_\_\_
- Do you feel safe in your home?  Yes  No Are you afraid of anyone? \_\_\_\_\_
- Is there a gun in your home?  Yes  No If so, is the gun locked when not in use?  Yes  No
- Has anyone ever threatened/hit/pushed/abused you? \_\_\_\_\_
- Have you ever been forced to have sex/do something sexual you didn't want to do?  Yes  No
- Smoke -  Yes  No How much \_\_\_\_\_ How long \_\_\_\_\_
- Drink -  Yes  No How much \_\_\_\_\_ How long \_\_\_\_\_
- Marijuana/cocaine/other - Yes  No  How often \_\_\_\_\_ How long \_\_\_\_\_

**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



# No Show Policy Change

**Beginning January 1, 2023**, established patients who **no-show** for their scheduled appointment **2 times within 12 months** will not be able to schedule appointments in advance.



**Questions??**

**Talk with one of our staff members**

**Unable to keep your appointment?**

**Call: 269-965-8866**



Not feeling well?

Have questions about your health?

**Call Us First!**  
**269-965-8866**

Call and ask to speak with a nurse,  
***24-hours a day, 7 days a week.***

***Our nurses are here to help you decide on next steps by:***

- *Listening to your concerns*
- *Collecting information to better support you*
- *Providing you with clinical advice*
- *Assisting you in scheduling an appointment if needed.*

***To better accommodate your needs, we now have multiple open appointments at the start of the day.***

*Our scheduling team is available to take your call beginning at **7:30 am.***



**grace**  
HEALTH