ZMC
ZAWAIDEH MEDICAL CENTER

ph 248.280.6400 • *fx* 248.273.0471 • 1041 S. MAIN ST. • ROYAL OAK • MICHIGAN 48067

Zawaideh Medical Center
1041 S. Main St.
Royal Oak, MI 48067
248.280.6400
248.273. 0471 fax

Dear New Patient,

Thank you for selecting Zawaideh Medical Center as your partner in health. We look forward to meeting you at your upcoming appointment. Please complete the attached new patient paperwork and either mail it to our office or bring it to your first appointment along with a copy of any insurance cards and a picture ID.

Our office is located just south of downtown Royal Oak between Lincoln and the I-696 service drive near Holiday Market. Parking is available at our facility in either the North parking lot (on Main St.) or behind the building in the East parking lots. Both lots have an entrance to the building that will lead to you to our office located on the first floor adjacent to ZMC Pharmacy.

If you need more detailed directions to our facility or have any other questions, feel free to contact our office at 248.280.6400.

Thank you,

Zawaideh Medical Center

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Personal Information

Last name:_____ First name:_____ Middle:_____

Address:_____ City:_____ State:_____ Zip: _____

SSN:_____ Gender: ☐ Male ☐ Female D.O.B._____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Ethnicity/Race:_____

Home Phone:_____ Cell phone:_____ Email:_____

Occupation:_____ Employer:_____ Work Phone:_____

Preferred method of contact: ☐ Email ☐ Cell phone ☐ Home phone ☐ Other_____

Permission to leave a message on your voicemail: ☐ Yes ☐ No

Referred by:_____
Relation:_____

Emergency contact:_____ Phone:_____ Relation:_____

Do you have an Advanced Directive ☐ Yes ☐ No

Insurance Information

Member name:_____ ☐ Self ☐ Spouse ☐ Parent

Name of Insurer:_____ State:_____ Plan #: _____

Other Healthcare Providers/Specialist

Name	Phone number	Reason

Medication/Vitamin Information

Current Medications - Use a separate sheet if necessary

Medication/Vitamins	Dosage	Frequency

Allergy Information

Medication/Supplement/Food	Date	Reaction

Past Surgical History and Hospitalizations

Date	Condition/Reason

Patient Intake Form

Relationships ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnerships ☐ Gay/Lesbian ☐ Bi-Sexual

Number of Children

How many people living in household?

Pets

Social History

Smoking

☐ Currently smoking

- ☐ How Many Years?_____
- ☐ Packs per day?_____
- ☐ Attempts to quit?_____

Previous Smoking

Quit Date _____

Prior to quitting

- ☐ How Many Years?_____
- ☐ Packs per day?_____

Alcohol Intake

How many drinks currently per week?_____

_____

Caffeine Intake (pop/coffee/tea)

How many per day?_____

_____

For Women

Last menstrual period	
Last pap smear	
Last mammogram	
Last bone density	

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History

Have any of your family members had any of the following problems?

X	Condition:	
	Heart Disease/attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family Member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer	

Other medical problems not on this list:

_____

_____

Past Medical History

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A, B, C)		Seizures	
Cancer (What kind)		High Blood Pressure		Sexually Trans. Disease	
Chronic Bronchitis		High Cholesterol		(specify)	
Crohn's Disease or IBS		Kidney Disease		Stomach Ulcers	
Colon Po!yps		Kidney Infections		Stroke	
Depression		Kidney Stones		Tuberculosis	
Diabetes		Lupus		Thyroid Disease	
Diverticulitis		Melanoma or Skin Cancer		Ulcerative Colitis	
Drug Abuse		Migraines		Warts	
Eating Disorder		Osteoarthritis			

Other medical problems not on this list:

_____

_____

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my Insurance Companies.

I understand that I am responsible for my bill including co-payments and deductibles.

I authorize Zawaideh Medical Center, PC to act as my agent in helping me obtain payment from my insurance companies.

I authorize direct payment to Zawaideh Medical Center, PC.

I permit a copy of this authorization to be used in place of the original.

Signature Patient/Guardian_____Date_____

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General Consent to Outpatient Treatment

I request and authorize Zawaideh Medical Center and its physicians, assistants or designees to provide me with medical care as they deem necessary or advisable. This care may include, but is not limited to, routine diagnostic procedures, radiology, laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my physician to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedures or treatments.

I understand that samples of bodily fluids and/or tissues may be withdrawn from me (the pat ient) during routine diagnostics procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues.

I have been informed and understand that an HIV (human immunodeficiency virus-AIDS) test may be performed on me without my consent if a health professional, faci lity employee or First Response sustains an exposure to my blood or other bodily fluid.

Assignment of Insurance Benefits

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the faci lity, benefits otherwise payable to me. I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.

I have had the opportunity to read this form (or have it read to me), ask questions, and have these questions answered.

Acknowledgement of Privacy Practices

The Zawaideh Medical Center Notice of Privacy Pra ctices provides information about how protected health information about me (the patient)- including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records, including communications made by me to a social worker or psychologist (if any)- may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and I may obtain a copy at my next office visit.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the Zawaideh Medical Center's Notice of Privacy Practices

By signing this form, I acknowledge that I have been offered and/or received the Zawaideh Medical Center's no show policy.

Signature of Patient_____ Date _____

Consent of legal Guardian, Patient Advocate or nearest relative if patient is unable to sign or is a minor.

_____ Date _____ Relationship _____

Signature of Guardian, Patient Advocate or Nearest Relative

Signature of witness _____

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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.*

Protected Information. While receiving care from our facility, information regarding your medical history, treatment, and payment for your health care may be originated and/or received by us. Information which can be used to identify you and which relates to your past, present or future medical condition, receipt of health care or payment for health care is known as "Protected Information".

OHCA with ZMC Pharmacy. While receiving care from our facility, your Protected Information will be available to ZMC Pharmacy pursuant to an Organized Health care Arrangement that facilitates the integration of certain clinical and treatment functions between both entities, including medication selection, medication review/adjustment, medication consultation, vaccination administration, and insurance/benefit verification, which maximize our ability to deliver optimal health care to you. By signing this Notice, you understand that you are also a patient of ZMC Pharmacy and, accordingly, a copy of ZMC Pharmacy's Notice of Privacy Practices is available to you.

Our Responsibilities. Federal law imposes certain obligations and duties upon us as a covered health care provider with respect to your Protected Information.

Specifically, we are required to:

- Provide you with notice of our legal duties and our facility's policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentiality of your Protected Information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information unless under the law we are authorized to release your Protected Information without your authorization, in which case you will be notified within a reasonable period of time;
- Allow you to inspect and copy your protected Information within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension;
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods; and
- Abide by the terms of this notice.

How Protected Information May be Used and Disclosed. Generally, your Protected Information may be used and disclosed by us only with your express written authorization. However, there are some exceptions to this general rule.

Treatment, Payment, or Health Care Operations.

Treatment Purposes. We may use or disclose your Protected Information for treatment purposes. During your care at our facility, it may be necessary for various personnel involved in your care to have access to your Protected Information in order to provide you with quality care. For example, other physicians that are involved with your ongoing health or mental care, nurses, technicians, pharmacists, and other personnel who take care of you will have access to your Protected Information. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you.

*Please note, we reserve the right to revise our practices with respect to Protected Information and to amend this notice. Should our information practices change, we will post at the receptionist's desk where you can obtain a current notice from the receptionist.

Payment Purposes. Your Protected Information may also be used or disclosed for payment purposes. It is necessary for us to use or disclose Protected Information so that treatment and services provided by us may be billed and collected from you, your insurance company, or other third party payer. It may also be necessary to release information to another health care provider or individual or entity covered by the HIPAA privacy regulations which has a relationship with you for its fraud and abuse detection or compliance purposes, quality assessment and improvement activities, or review, evaluation or training of health care professionals or students.

Notification and Communications to Individuals Involved in Your Care. Unless you have informed us otherwise, you Protected Information may be used or disclosed by us to notify or assist in notifying a family member or other person responsible for your care. In most cases, Protected Information disclosed for notification purposes will be limited to your name, location and general condition. In addition, if you have informed us of your consent, Protected Information may be released to a family member, relative or close personal friend who is involved in your care to the extent necessary for them to participate in your care. In event that you wish for any of these uses or disclosures to be limited, you would have to sign a release.

Business Associates. We may provide medical information to other persons or organizations, known as business associates, who provide services for Zawaideh Medical Center under contract. We require our business associates to protect the medical information we provide to them.

Health-Related Benefits and Services. We may use and provide medical information to tell you about health related benefits or services of interest.

Treatment Alternatives. We may use and provide medical information to tell you about possible treatment options or other items of interest.

Emergencies. We may use and disclose your protected health information in an emergency situation. If this happens, your physician shall try to obtain your consent as soon as reasonable practice and delivery of treatment allows. If your physician or another physician in the group is required or permitted by law to treat you and the physician has attempted, but has been unable, to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers. You understand and agree that Zawaideh Medical Center may use and/or disclose your protected health information should any medical situation arise where direct and immediate consent is required, but could not be obtained from you as the result of communication barriers, either written or verbal, and our physician determines, in his/her professional judgment, that circumstances warrant such use and/or disclosure.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object. We may use or disclose your protected health information in the following situations without your consent or authorization.

Required By Law. We may use or disclose your Protected Information to law enforcement officials for the following purposes:

- Pursuant to a court order, warrant, subpoena/summons, or administrativerequest;

- Identifying or locating a suspect, fugitive, material witness or missingperson;
- Regarding a crime victim, but only if the victim consents or the victim is unable to consent due to incapacity and the information is needed to determine if a crime has occurred, non-disclosure would significantly hinder the investigation, and disclosure is in the victim's best interest.
- Regarding a decedent, to alert law enforcement that the individual's death was caused by suspected criminal conduct; or
- By emergency care personnel if the information is necessary to alert law enforcement of a crime, the location of a crime, or characteristics of the perpetrator.

Public Health. We may disclose your protected health information for public health purposes to a public health authority that is permitted by law to collect or receive the information; disclosure will be made for the purpose of controlling disease, injury or disability.

Communicable Diseases. We may disclose your protected health information if you may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, in which case the disclosure is made consistent with the requirements of applicable federal and state laws.

Abuse or Neglect. We may disclose your protected information to a public health official or authority authorized by law to receive reports of abuse or neglect. In addition, we may discuss health information if we believe that you have been a victim of abuse, neglect or domestic abuse, in which case the disclosure is made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration. We may disclose your protected health information to a company required by the Food and Drug Administration to report adverse events, product problems, biologic product deviations, track products; to enable product recalls; to make recall replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings. We may disclose protected health information in the course of any judicial administrative proceeding, in response to a court or administrativetribunal in certain conditions in response to a subpoena, or other lawful process.

Coroners, Funeral Directors, and Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the medical examiner to perform other duties authorized by law. We may also disclose protected information to a funeral director, as necessary to perform his/her duties. We may disclose such information in reasonable anticipation of death. Protected Information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

Worker's Compensation. We are allowed to disclose your Protected Information as authorized and to the extent necessary to comply with laws relating to workers' compensation or other programs providing benefits for work related injuries or illness without regard to fault.

More Stringent Laws. Some of your Protected Information may be subject to other laws and regulations and afforded greater protection than what is outlined in this Notice. For instance, HIV 1 AIDS, substance abuse, and mental health information are often given more protection. In the event your Protected Information is afforded greater protection under federal or state law, we will comply with the applicable law.

You have the right to inspect and copy your protected health information.
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set"

contains medical and billing information and any other records that Zawaideh Medical Center uses for making decisions about you.

Under federal law, however you may not inspect or copy the following records: psychotherapy records or notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be review able. In some circumstances, you may have the right to have this decision reviewed.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this "Notice of Privacy Practices." Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If the physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with the physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation of you as to the basis for the request. **Please make this request in writing to our office.**

You have the right to have your physician amend your protected health information.
This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the office to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
The right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the 11Notice of Privacy Practices." It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, for notification purposes, or to Direct Rx pursuant to an Organized Health Care Arrangement. Your right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to receive a copy of the notice from us upon request.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a compliant with us by notifying our privacy contact person here at Zawaideh Medical Center.