FAMILY MEDICINE AND WELLNESS, PLLC **NEW PATIENT REGISTRATION**

Roufaida N. Al-Misky, MD, FAAFP

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Name_____Birthdate_____ Age_____ Gender: M / F
LAST FIRST

Pronouns: [She/Her/Hers]☐ [He/Him/His]☐ [They/Them/Theirs]☐ Not listed☐

Marital Status: Married☐ Single☐ Divorced☐ Widowed☐

Address_____

City_____State_____Zip Code_____

Cell Phone_____Preferred Phone_____

Race/Ethnicity_____Preferred Language_____

Do You Consent to Electronic Communication by Text and Email? Yes☐ No☐

Reminders & Practice Communication_____
EMAIL ADDRESS PREFERRED PHONE #

Legal Parent/Guardian (for minors) _____Spouse_____

Occupation_____Employer_____

Preferred Pharmacy_____
NAME ADDRESS PHONE #

How did you hear about us? _____

Advance Directive or Living Will? Yes☐ No☐

Emergency Contact_____
NAME RELATIONSHIP PHONE #

Permission to disclose personal health information to this person? Yes☐ No☐

Per HIPPA regulations, list family or friends that you would like our office to discuss or release your personal health information.

_____
NAME RELATIONSHIP PHONE #

_____
NAME RELATIONSHIP PHONE #

Signature_____Date_____

FAMILY MEDICINE AND WELLNESS, PLLC
Roufaida N. Al-Misky, MD, FAAFP

CONFIDENTIAL PATIENT MEDICAL HISTORY

Please answer all questions to ensure the highest quality of care. If something does not apply to you, please leave blank.

NAME_____BIRTHDATE_____AGE_____

Do you currently have or have you had any of the following? Check all that apply. Please specify (if applicable) below in the provided spaces.

— Anemia
— Angina
— Anxiety
— Arthritis Type_____
— Artificial Joints
— Asthma
— Autoimmune Disease
— Back Problems/Injury
— Bladder Problems
— Bleeding/Clotting Disorder
— Cancer Type_____
— Cardiac Defibrillator
— Cardiac Pacemaker
— Chronic Bronchitis
— Colon Disease
— Congestive Heart Failure
— Depression
— Diabetes
— Ear Problems
— Eating Disorder
— Emphysema/COPD
— Eye Disorder
— Fractures/Broken Bones
— Gout
— Hay Fever/Allergies
— Head Injury
— Heart Attack
— Hemorrhoids
— Heart Disease
— Hepatitis Type_____
— Hiatal Hernia
— High Blood Pressure
— High Cholesterol
— HIV
— Kidney Disease/stones
— Liver Disease
— Lung Disease
— Lupus
— Nerve Damage
— Neurological Disease
— Osteoporosis
— Phlebitis/Vein Problems
— Pneumonia
— Prostate Problems
— Prediabetes
— Psychiatric/Mental Health Issues
— Radiation Therapy
— Recent Weight Loss
— SARS-CoV-2/COVID 19
— Seizures/Epilepsy
— Shingles/Zoster
— Skin Problems
— STI/STD Type_____
— Stomach Disease
— Stroke
— Thyroid Disease
— Trauma
— Ulcers of Stomach
— Violence
— Other_____
— Other_____

_____

_____

_____

MAJOR HOSPITALIZATIONS DIAGNOSIS DATE

1._____

2._____

OPERATIONS OR PROCEDURES DIAGNOSIS DATE

1._____

2._____

LIST ANY KNOWN <u>ALLERGIES</u> TO MEDICATIONS, FOODS, ENVIRONMENTAL/LATEX REACTION?

1._____

2._____

LIST PHYSICIANS WHO CURRENTLY TREAT YOU SPECIALTY DIAGNOSIS

1._____

2._____

FAMILY MEDICINE AND WELLNESS, PLLC
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CONFIDENTIAL PATIENT FAMILY HISTORY

Disease	Relationship(s) (please specify maternal (mother's side) or paternal (father's side) if applicable)
Heart Disease	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Diabetes	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Stroke	□ Mother □ Father □ Sibling (Male/Female) □ Other (s)
High Cholesterol	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Hypertension	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Kidney Disease	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Bleeding Disorders	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Genetic Disorders	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Mental Health (i.e. Depression) (PLEASE SPECIFY TYPE OF ILLNESS/PROBLEM)	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
GI Disease	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)
Cancers (PLEASE SPECIFY TYPE)	□ Mother □ Father □ Sibling (Male/Female) □ Other(s)

Family Medicine and Wellness, PLLC Roufaida N. Al-Misky, MD, FAAFP
1579 W Big Beaver RD, STE B5, Troy, MI 48084-3504
Phone 248.759.0993 info@dralmisky.com

PATIENT MEDICATION/VACCINATION/SOCIAL HISTORY

NAME_____**BIRTHDATE**_____**DATE**_____

MEDICATION LIST

Please include prescriptions, patches, inhalers, drops, medication implants or pumps, over the counter medications vitamins/supplements, & herbal products.

Medication	**Dose**	**Instructions for use**
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY

Smoking:

Tobacco: Never____ Occasional(monthly) _____ Frequently(weekly)_____ Daily_____
Did you smoke tobacco in the past? _____ How many years? _____ When did you quit?_____

Vaping: Never_____Occasional(monthly) _____ Frequently(weekly)_____ Daily_____
Did you vape in the past? _____ How many years? _____ When did you quit? _____

Alcohol Consumption: Never_____ Occasional(monthly)_____ Frequently(weekly)_____ Daily_____

Recreation Drugs? YES / NO What kind? _____

Sexually Active? YES / NO How many lifetime partners? ____ Female Partners / Male Partners / Both (circle)

VACCINATIONS

Are you up to date on immunizations? YES / NO

Please circle if you have had the following vaccines:		*Are you interested in receiving?*
YES / NO	TDAP (Tetanus, Diphtheria, Pertussis)	INTERESTED / NOT INTERESTED
YES / NO	FLU (Influenza)	INTERESTED / NOT INTERESTED
YES / NO	PCV13, PCV15, PCV20, PPSV23 (Pneumococcal)	INTERESTED / NOT INTERESTED
YES / NO	HEP B (HEPATITIS B)	INTERESTED / NOT INTERESTED
YES / NO	HPV (Human Papillomavirus)	INTERESTED / NOT INTERESTED
YES / NO	RZV (Shingles)	INTERESTED / NOT INTERESTED
YES / NO	RSV (Respiratory Syncytial Virus)	INTERESTED / NOT INTERESTED
YES / NO	COVID-19 (Coronavirus disease 2019)	INTERESTED / NOT INTERESTED

NOTICE OF PRIVACY PRACTICES PRIVACY REGULATION CONSENT

Family Medicine and Wellness, PLLC Roufaida N. Al-Misky, MD, FAAFP
1579 W Big Beaver RD, STE B 05, Troy, MI 48084-3504 info@dralmisky.com Phone 248.759.0993 Fax 833.955.3554

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

The **Health Insurance Portability and Accountability Act of 1996 (HIPPA)** is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, the right to understand and control how your protected health information (PHI) is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

1. **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is Dr. Roufaida Al-Misky referring you to a specialist physician.

2. **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing activities, and utilization review. An example of this would include sending your insurance company a bill for your visit.

3. **Healthcare operations** include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service.

4. The practice may also be required or permitted to disclose your PHI for **law enforcement as required by federal, state or local law and other legitimate reasons**. In all situations, we shall do our best to assure its continued confidentially to the extent possible.

We may **contact you by phone, email, text or in writing,** to provide appointment reminders or your medication at a pharmacy is ready or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Other ways your health information may be used or shared. We are allowed or required to share in ways that contribute to the public good, for example research and public health. Many conditions have to be met in the law before we can share this information. https://www.hhs.gov/hipaa/index.html

Use and disclosure of your PHI in certain special circumstances:

1.Public health and safety issues. Our office may disclose your PHI to public health authorities to maintain vital records, report suspected abuse, neglect or domestic violence, report adverse reactions to medications or problems with products or devices, prevent disease, or prevent or reduce a serious threat to anyone's health or safety or to the public.

2.Comply with the law. We will share information about you if state or federal laws require it. Our practice may use and disclose your PHI to a health oversight agency for activities authorized by law. This could include inspections, investigations, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the healthcare system in general. An example is the Department of Health and Human Services to determine if we are in compliance with federal privacy law.

3.Lawsuits and similar proceedings. Our practice may share your PHI in response to a court or administrative order or in response to a subpoena.

4.Our practice may release PHI to a **medical examiner, or coroner or funeral director** for a deceased Individual.

5. If you are an organ donor, our practice may release your PHI to **organ procurement organizations** for organ and tissue donation requests.

6. Our practice may use and disclose PHI for **health research** purposes.

7. We may disclose or share health information about you for **workers compensation, law enforcement purposes or to law enforcement officials, or to special government requests** for special government functions such as the military, national security, and presidential protective services.

Other uses and disclosures of PHI not described in this notice will only be made pursuant to us receiving a written authorization from you. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization. Also, a written authorization is required for most uses or disclosures of psychotherapy notes.

You may have the following rights with respect to your PHI:

1.The **right to request restrictions on certain uses and disclosures of PHI**, including those related to disclosures to family members, or any other person identified by you, who may be involved in your care or for notification purposes. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it except when required by law, in emergencies or when information is necessary to treat you unless you agree in writing to remove it.

2. The **right to reasonable requests to receive confidential communications of PHI** by alternative means or at alternative locations.

3. The **right to inspect and copy your PHI**.

4. The **right to amend your PHI**. We may ask you to make the request in writing and state the reason. We may so no but will tell you why in writing within 60 days.

5. The **right to receive an accounting of disclosures of your PHI**.

6. The **right to obtain a paper copy of this notice** from us upon request at any time. You can view a copy of this notice on our website www.familymedicineandwellness.com and in the lobby.

7. The right to choose someone to act for you. If a person has the authority to act for you, such as your **medical power of attorney or legal guardian, that person can exercise your rights, and make decisions about your health information**. You or your personal representative may need to provide authorizing paperwork before we can evaluate if the person has this authority and can act for you before we take any action.

8. The **right to be advised if your unprotected PHI** is intentionally or unintentionally disclosed.

9. **The right to limit what information we use or share.** If you have paid for services “out of pocket”, in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

10. You have **the right and choice to tell us to share your information in a disaster situation.**

We will comply with and abide by all applicable state and federal laws. For the state of Michigan there are more limits on the disclosure of HIV and AIDS, substance abuse information and mental health information.

We may participate in a **Health Information Exchange** that allows electronic transfer of PHI between healthcare providers to coordinate treatment.

We are required by law to maintain the privacy and security of your PHI. We must follow the privacy practices described in this notice and to provide you the notice of our legal duties and our privacy practices with respect to PHI.

This notice is effective as of August 1, 2021 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by your office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint. Visit https://www.hhs.gov/hipaa/filing-a-complaint/index.html, or write to 200 Independence Ave, SW Washington, DC 20201, or call 1-800-368-1019.

Please contact Dr. Al-Misky at 248-759-0993, or in person or in writing or info@dralmisky.com with questions or for more information regarding this notice or our health information privacy policies.

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PRIVACY PRACTICES AND CONSENT TO TREAT ACKNOWLEDGEMENT

I certify that I have been issued the HIPPA Notice of Privacy Practices, and I have reviewed it. I fully understand that Family Medicine and Wellness, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services, and conducting health care operations.

NAME_____BIRTHDATE_____

SIGNATURE_____DATE_____
PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE

I acknowledge Family Medicine and Wellness, PLLC is a Patient-Centered Medical Home and choose to participate. A Patient-Centered Medical Home is a Partnership Between the Patient and his/her Physician.

SIGNATURE_____Date_____
PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE

MEDICAL CARE CONSENT

I give consent to Roufaida Al-Misky, MD, FAAFP of Family Medicine and Wellness, PLLC to perform and provide medical care, tests, or procedures as agreed upon in the best interest of my health.

Initial Here_____

CONSENT TO OBTAIN PRESCRIPTION HISTORY

In an effort to improve the quality and safety of our patient care, we may require your current prescription medications. I agree that Family Medicine and Wellness, PLLC may request my current prescription history from third party pharmacy benefit payors for treatment purposes.

Initial Here_____

PAYMENT RESPONSIBILITY

I authorize Dr. Roufaida Al-Misky to bill my insurance carrier, and when needed to release any medical or personal information that is required to process the claim on my behalf. I acknowledge and agree that I am fully responsible for all costs incurred for my treatment in the office of Family Medicine and Wellness, PLLC. I understand payment and / or copay is preferred on the date of service.

Initial Here_____

CANCELLATION AND NO-SHOW POLICY

We understand that sometimes it is necessary to reschedule an appointment. We request at least 48 hours notification prior to cancelling and will gladly reschedule. A no show is a scheduled appointment not kept by the patient. For the first instance, we will call or email you to remind you of the missed appointment. For the second instance, you will be charged $25, and for the third instance you will be charged $45. We regret any inconvenience this may cause you, but we appreciate your help in keeping an orderly schedule so that we can better serve all our patients.

Initial Here_____

NAME_____DATE_____
SIGNATURE_____
PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE

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CONSENT FOR COMMUNICATION VIA E-MAIL

Please print clearly. Check here if you wish to decline consent. _____

I, patient name: _____

Email Address: _____

Hereby consent to have Dr. Al-Misky at Family Medicine and Wellness, PLLC or Family Medicine and Wellness staff members communicate with me, or Family Medicine and Wellness staff, or other physicians, physician assistants, nurse practitioners, other health professionals, and pharmacists via email regarding aspects of my medical care, treatment, test results, prescriptions, appointments, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my practitioner and me or members of my practitioner's office and other practitioners, or pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my practitioner and me or members of the office staff or between my practitioner and other practitioners, or pharmacists regarding my medical care may be printed out and made part of my medical record. I understand that in urgent or emergent situations I should go to the Emergency Room and not rely on e-mail.

Patient Name: _____ Date: _____

Signature: _____

PATIENT OR PARENT/GUARDIAN IF MINOR OR PATIENT REPRESENTATIVE