New Patient Medical Form (Please use BLACK ink)

If form is not filled out completely, it may result in a delay in scheduling

Please indicate which practice you are applying for by checking the box next to the location.

[] Clinton County Medical Center – St Johns, MI **[] CCMC – Ferguson Campus – Carson City, MI**

Patient Name: _____

First *Middle Initial* *Last*

Address: _____

Street *City* *State* *Zip Code*

Home Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Work Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Cell Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Gender: [] Female [] Male **Date of Birth:** ___ ___/___ ___/___ ___ ___ ___

Marital Status: [] Single [] Married [] Divorced [] Windowed [] Separated

Race: [] American Indian or Alaska Native [] Asian [] Black or African American [] Native Hawaiian or Other Pacific Islander [] White [] Decline to Comment

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Decline to Comment

Preferred Language: [] English [] Spanish [] Other: _____

Employment Status: [] Full Time [] Part Time [] Not Employed [] Self-employed [] Retired [] Military Duty

Employer Name: _____

Email address: __

Responsible Party Name: (if different than patient)

_____

First *Middle Initial* *Last*

_____

Address (if different than patient)

Responsible Party Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Gender: [] Female [] Male Relationship to patient: _____

Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Emergency Contact:

_____

First *Middle Initial* *Last*

_____

Address (if different than patient)

Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Gender: [] Female [] Male Relationship to patient: _____

Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Insurance Information

Primary Insurance:

Carrier Name: _____

Subscriber Name: _____

Subscriber Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Certificate Number: _____ Group Number: _____

Patient's Relationship to Subscriber: [] Self [] Spouse [] Child [] Other

Secondary Insurance:

Carrier Name: _____

Subscriber Name: _____

Subscriber Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Certificate Number: _____ Group Number: _____

Patient's Relationship to Subscriber: [] Self [] Spouse [] Child [] Other

Tertiary Insurance:

Carrier Name: _____

Subscriber Name: _____

Subscriber Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Certificate Number: _____ Group Number: _____

Patient's Relationship to Subscriber: [] Self [] Spouse [] Child [] Other

♦ Please briefly state in the box below the reason for your visit ♦

♦ Medication or Food Allergies or Intolerances ♦ *List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦					
High Blood Pressure Medication	***Strength***	***Number of pills taken & frequency***	***Pain Medication***	***Strength***	***Number of pills taken & frequency***
Diabetes Medication	***Strength***	***Number of pills taken & frequency***	***Depression/Anxiety Medication***	***Strength***	***Number of pills taken & frequency***
Sleep Medication	***Strength***	***Number of pills taken & frequency***	***Medical Marijuana***	***Dosage***	***Name of Physician that prescribes this***
Vitamins & Supplements	***Strength***	***Number of pills taken & frequency***	***Other Medication***	***Strength***	***Number of pills taken & frequency***

**Add additional medications, vitamins, and supplements to the next page.

Do you give permission to Clinton County Medical Center access your hospital medical record through Sparrow, McLaren, and Mid-Michigan Medical Center to verify your medications and medical diagnosis's? [] Yes [] No

Do you give permission to Clinton County Medical Center call your pharmacy to access your medication list? [] Yes Pharmacy Name: _____ [] No

Patient or Guarantor Signature: _____

AUTHORIZATION TO RELEASE INFORMATION, TREATMENT OF A MINOR, AND ASSIGNMENT OF BENEFITS

I understand that as part of my health care, this organization originated and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I authorize Clinton County Medical Center to bill and release to private insurance carriers such information from my patient records as is required in order to receive reimbursement for any billings for services. This includes alcohol and drug abuse and mental health treatment information protected under the regulations in title 42 or code of Federal Regulations Part II. Information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) as defined by the Department of Public Health rules Act 174 1989 and Act 368 Public Act 1978.

I request that payment of authorized benefits (if billed by the office) be paid directly to Clinton County Medical Center on my behalf. This is an authorization agreement, until such time as revoked by me and a yearly update is required. I understand that I am responsible for/hereby accept responsibility for the payment to Clinton County Medical Center for whatsoever sums of money shall become due and payable for services received. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I certify that all statement made on this application are true.

I authorize Clinton County Medical Center staff to discuss my medical and billing information with the following person(s): (This may include family members, friends, neighbors, or anyone else you designate):

Name & Phone number (if possible)	Relationship to patient	Info to be released (Please circle)
		Medical, Financial, Mental Health, or all
		Medical, Financial, Mental Health, or all
		Medical, Financial, Mental Health, or all

★ ____ ____________ ______________

Signature of Patient or Legal Representative Date Initials of Witness

~

REQUEST AND CONSENT FOR TREATMENT OF MINOR CHILDREN (IN THE ABSENCE OF PARENT OR GUARDIAN)

As a parent or guardian, I, ________________________________, hereby request and give my full consent for medical care, treatment and/or surgery, and authorize hospital admission, as the treating physician may deem medically necessary, for my child during my absence. This is a lifetime authorization agreement, until such time as revoked by me. However, a yearly update is required.

Listed below are the individual(s) that are authorized to make medical decisions and bring my child in for medical treatment in my absence. (You may use the back of this form as well)

Name	Phone	Relationship

★ ____ ____________ ______________

Signature of Patient or Legal Representative Date Initials of Witness

Our Mission:

Clinton County Medical Center will provide extraordinary patient care with a comfortable and safe atmosphere in a world of advancing medical technology.

Office Policies

1. You should always call 911 or go directly to the ER for all life-threatening emergencies. However, in our office we strive to accommodate patients who need urgent treatment. For this reason, we may be running late. We ask you to be patient with us, and allow flexibility in your schedule when planning your trip to CCMC.

2. Please bring the following to EACH appointment: **(1)** insurance card, **(2)** driver's license, **(3)** co-pay, **(4)** knowledge of your insurance plan coverage, **(5)** complete list of current medications.

3. When calling the office for an appointment, the receptionist will ask you the reason for your visit. By knowing what symptoms you have, she will best decide how much time is needed for you. In consideration of the physician's schedule, and of the people who have appointments after you, please tell the receptionist about ALL issues that you would like to discuss at your visit.

4. If you have an acute illness (i.e. sore throat, fever, flu), the receptionist will try to get you in to see the doctor as quickly as she can. To make this happen, she will fit you into a shorter time slot. The only thing that the provider will be able to address is the current acute illness. You will have to make a second appointment if you wish to discuss other issues.

5. A parent or guardian MUST accompany a child (under the age of 18) to appointments including, a physical, sports physical, or well child check (WCC). No exceptions.

6. If you have an appointment at the beginning of the morning (8 AM – 9 AM), or an appointment right after lunch (1 PM – 2 PM), it is ESSENTIAL that you arrive 15 minutes early.

7. Just one person running late can throw off our entire schedule, resulting in a lot of angry people. Please plan ahead for unexpected delays. For the sake of our other patients, people who show up more than 5 minutes late may be asked to reschedule.

8. We require a minimum of 24 hours - [or the Friday before a Monday appointment] - notice of cancellation. A fee of $50 is charged for non-cancelled and missed appointments. A pattern of non-cancelled and missed appointments may result in discharge from the practice.

9. The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record.

10. Our goal, as a Patient Centered Medical Home, is to provide extraordinary medical care to you and your family that is relationship-based with an orientation toward the whole person. In order to continue to provide you with the very best care, CCMC requires each patient to schedule an annual preventative care examination. Having this preventative care examination annually will help ensure that you maintain an active status with our office.

11. Insurance companies do not pay all fees and may exclude certain services from coverage. IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN.

12. Co-pays are expected to be paid at the time of service. Failure to pay will result in a $10.00 billing fee.

13. Depending on your insurance, our referral department may schedule your visit to see a specialist or have an MRI/CT scan performed. Information regarding the appointment will be mailed to you, unless it is urgent. **Please allow 14 days for your referral appointment to be processed.** If you have not been contacted by CCMC or the facility you are being referred to in 14 days, please call us to check on the status of your referral.

14. It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. MEDICATIONS ARE REFILLED ONLY AT THE PATIENT VISIT. This includes all mail-order prescriptions. WE CANNOT TAKE PHONE CALL REFILL REQUESTS.

15. At CCMC we take our prescribing of controlled substances very seriously. Our providers use a multi-faceted approach to treat patients, and medication—including controlled substances—are only one part of our treatment plans. We believe in making sure that each medicine you take is exactly right for you and your individual situation, and finding a long term solution is more important to us than just treating patients' symptoms.

16. For your convenience, most lab tests and diagnostic studies are performed on-site at CCMC. After your lab test or diagnostic study is finished, the results will be reviewed by your provider. Your provider, or their nurse, will contact you right away if the results are critical. Normal results will be communicated through your Follow My Health Patient Portal Account. Abnormal results will require an office visit so we can discuss this in person and address any questions you may have. Please note: Because we handle a large number of phone calls, **please call only if you have not heard from us more than 14 days after the tests were done.**

17. Laws and Regulations at the Federal and State level, as well as conditions set forth by many insurance companies, place heavy and complex restrictions upon us with regard to the way we determine fees for office visits. We have very little leeway in these matters. As a result, your provider has no ability or authority to influence the amount you are charged for our services.

18. The fee charged for an office visit is determined by the level of complexity, which is not always known at the time of service. Per federal regulation, complexity is determined using a formula that takes into account both chronic and acute issues. A certified coder calculates the level of complexity to be charged after reviewing the chart notes.

19. If you are uninsured, a deposit of $110-$80 will be required at the time of service. Any additional fees will be billed after the visit.

20. Accounts more than 90 days old are subject to transfer to an outside collection agency, provided that they have not made special arrangements with us. Individuals who have come upon hard times are encouraged to work out a payment plan with our collection department.

21. A patient knowingly asking CCMC to submit false information to an insurance company in order to get them to pay for something that they ordinarily would not cover is committing fraud. Such a request will be denied. This includes asking a screening procedure to be submitted as diagnostic when no illness/injury is present. If you do not know if your insurance company covers a particular test, procedure or injection, it is your right to postpone the service so you can call your insurance.

22. Verbal abuse or threatening behavior towards providers and staff will not be tolerated.

23. The practice reserves the right to discharge a patient for any reason at any time, with or without notice. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

I have read and understand all the terms of this policy:

Patients Name _____
(Please Print)

Signature: _____
(Guarantor)

Date: _____

Health Information Portability and Privacy Act (HIPPA) Notice

This NOTICE describes how information about you may be used, disclosed and how you can get access to this information review it carefully.

Understanding your Health Record / Information

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examinations, test results, diagnoses, treatment, and a plan for the future care or treatment. This information, often referred to as your health or medical record, serves as a;

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
    - A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information.
- Make more informed decisions when authorizing disclosure to others.

Your health information rights

Although your health record is the physical property of the health care practitioner of facility that compiled it, the information belongs to you.

You have the right to:

Request a restriction on certain uses and disclosures of certain parts of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that we not disclose your health information 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.

(The practice is not required to agree to a restriction that you may request. We will notify you that we deny your request to a restriction. We may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the

Office Manager/Privacy Officer.

You have the right to:

- Obtain a paper copy of the Notice of Information Practices upon request.
- Inspect and have a copy of your health record.
- Amend your health record if appropriate.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative to use or disclose information except to the extent that action has already been taken.

Our Responsibilities

This organization is required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a reasonable restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means of at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide a revised notice upon your next visit to the practice.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Office Manager/Privacy Officer at (989)224-3000

If you believe your privacy rights have been violated, you can file a complaint with the Office Manager of Secretary of Health and Human Service.

Example of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the Risk of Quality Improvement Manger, of members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include with physician services in the Emergency Department and radiology, certain laboratory tests, and copy services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered.

To protect your health information, however, we require the business associates to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation to other people who ask for you by name.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

Fund Raising: we may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged either preventing or controlling disease, injury, or disability.

Correctional Institutions: Should you be an inmate of a correctional Institution, we may disclose to the institution, or agents thereof, health information necessary for your health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your information to be released to an appropriate health oversight agency , public health authority or attorney, provided that a work force member or business associate believes in good faith that we have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

HIPAA NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been advised of the Notice of Privacy Practices at Clinton County Medical Center and that a copy of this policy is available to me.

Date: _____

Patient's Name (Please Print)

☆

Patient or Representative Signature Representative's Relationship to Patient

Clinic Representative: _____

Clinton County Medical Center
Patient's Authorization for Release of Protected Health Information

This form for Authorization for Release of Protected Health Information is designed to comply with Title 42 of Federal Regulations, Part 2 (regarding alcohol and substance abuse records) and/or state laws respecting confidentiality of records and patient communications with mental health professionals, other healthcare providers and medical center support staff.

Patient's Name _____
Last First Middle Initial

Address
_____
Street City State Zip Code

Telephone _____ Date of Birth _____

The undersigned hereby authorizes:

_____,
Name and address of person(s) or organization(s) from which information is being requested

to release any and all information contained in the records of the patient listed above. INCLUDING INFORMATION REGARDING DRUG AND/OR ALCOHOL TREATMENT, PSYCHOLOGICAL AND SOCIAL SERVICES RECORDS, COMMUNICATIONS MADE TO A SOCIAL WORKER, PSYCHOLOGIST, OR PSYCHIATRIST, AND HIV/AIDS-RELATED COMPLEX DOCUMENTATION, to the individual(s) or organization(s) listed below.

Name of person(s) or organization(s) to whom disclosure is to be made:

Clinton County Medical Center
1005 S. US 27
Suite 100
St. Johns, MI 48879
Phone: 989-224-3000 Fax: 989-668-0423

Description of the specific information (include date(s) of service) to be used or disclosed _____

_____

This information is being requested for the following purpose(s):
[] At the request of the individual
[] Other, describe: _____
_____

This authorization is subject to revocation at any time, except to the extent that it has already taken action in reliance upon it. I may revoke this authorization in writing by contacting Medical Records (information from medical record) or Patient Accounts (information from billing record) at the address below. Unless earlier revoked, consent will expire 60 days from date signed.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

I understand that I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

I understand that Michigan law allows CCMC to charge a reasonable fee for the requested copies from the medical record.

[] If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

_____ _____
Signature of PATIENT or PATIENT'S LEGAL REPRESENTATIVE Date

If signed by a legal representative, indicate his/her relationship to the patient (parent, guardian, etc.) and attach legal documentation:

_____ _____
Witness to Signature Date

CCMC Wants to Know…
What Are *Your* Goals to Improve Your Health?

Choose one of the following, or come up with one of your own:


Eating Plan


Take Medications


Quit Smoking


Exercise


Reduce Alcohol Intake


Reduce Stress


Reduce Salt Intake


Weight Reductions


Self-Monitoring


Choose Your Own: _____


What will you do?

_____

_____


When will you do it?

_____

_____


Where will you do it?

_____

_____


How will you do it?

_____

_____

1. On a scale from 0 to 10:
   a. How important is this to you? 1 2 3 4 5 6 7 8 9 10
   b. How confident are you that you can achieve your goal? 1 2 3 4 5 6 7 8 9 10
2. What could make it difficult for you to reach your goal? _____

_____

3. What is your plan for overcoming these difficulties? _____

_____

We want to help you achieve your goal. We will follow-up with you on: _____

Some of the services we offer:

Urgent Services
Same day visits
Colds and flu
Pain
Asthma
Cuts and scrapes
Burns and rashes
Headaches and migraines
Broken bones
Sprains and strains
Nosebleeds

Physicals
Sports
School
Employment
Medicare Wellness

Addiction Medicine
Suboxone therapy
Smoking cessation
Weight control

Nutrition and Wellness
Weight loss program
Diabetic counseling
Nutrition counseling

Radiology Services
On-site Radiologist
X-ray
Bone density
Biopsies
Ultrasound

Pediatric Medicine
Wellness exams
Immunizations
Acute Illnesses

Esthetic Medicine
Permanent make up
Facial peels
Microderm

Physical Therapy
Back pain
Sports injuries
Joint pain
Neck pain
Post-surgical therapy
Pediatric & Geriatric conditions
Urinary incontinence
Parkinson's
Balance
Decrease risk of falls
Gait/Neuropathy

Occupational Medicine
On-the-job injuries
Drug screens
DOT testing

Cancer Screening
Mammogram
Colonoscopies
Lab testing
Skin cancer screening
Biopsies
Prostate screening
Lung cancer screening

Complete Lab Testing
Rapid strep/flu
Glucose
Protime
STD testing
Cholesterol
Drug Screening

Immunizations and Allergy Injections
Pediatric vaccines
Tetanus
Hepatitis A and B
Gardisil
Influenza

Cardiovascular Testing
Stress tests
EKG
Ultrasound
Echocardiogram

Foot Care
Plantar fasciitis
Nail trimming
Nerve testing
Orthotics

Women's Medicine/ Reproductive Health
Hormone replacement therapy
Urinary incontinence
STD testing
Pregnancy
Birth control
Mammograms
Vasectomies

CCMC
CLINTON COUNTY MEDICAL CENTER

1005 S. U.S. 27, Suite 100
St. Johns, MI 48879
Website: ClintonCountyMedicalCenter.com
Phone: 989-224-3000

CCMC
CLINTON COUNTY MEDICAL CENTER

Andrew W. Messenger, D.O., P.C.
Lars P. Andersen, JR., D.O., P.C.
Taylor Thelen, D.O.
Paul Minnick, D.O.
Maria Thelen, PA-C
Bryanna Weber, PA-C, R.D.
Justin Morris, PA-C
Danielle Martinez, NP
Amber Sprauge-Rice, NP
Vy Than, NP

CCMC Hours

Monday
7:00AM until 7:00PM
Tuesday-Friday
7:00AM until 5:00PM
Saturday
8:00AM until 12:00PM
On call physician available after hours

OUCH Urgent Care Hours

989-224-6897
Monday-Saturday
8:00AM until 8:00PM
Sunday
12:00PM until 6:00PM

A Patient-Centered Medical Home

CCMC
CLINTON COUNTY MEDICAL CENTER

Welcome to your medical home.
Patient-centered is a way of saying that you, the patient, are the most important person in the health care system. You are at the center of your health care. A medical home is an approach to providing total health care. With your medical home, you will join a team of medical professionals led by a personal physician to coordinate care and identify medical and community resources to meet your needs.

At Clinton County Medical Center, we believe that a medical home should be a trusting partnership between a doctor-led health care team and an informed patient. This includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

Helping You Make The Right Choices

We trust you, our patients, to respect us as partners in your health care and to keep us informed about:

- Your current health problems and any changes in your condition
- Any concerns you may have
- All of your prescriptions, including those from other physicians
- Your current insurance benefits
- Your current address and phone Number

As part of our patient-centered medical home orientation, we will ask you to acknowledge your agreement to the above and we will do the same for you. Our goal is to provide excellent care for you and your family.

We function as a physician-led team to help you set health and wellness goals and make a plan for your success:

- Care management services are available to advocate for your health
- Care managers work with you to help achieve your health goals

We will continue to:

- Provide you with a competent health care team that understands the needs of you and your family
- Respect your individuality and your privacy
- Be available to you 24 hours/day, 7 days/week

What can *you* do to help?

1. Be an active team player
• Talk with your team about your health questions. Share the successes and the challenges you've had with health care in the past.
• Tell your team about other health care professionals who care for you.
• Tell your team how you feel about the care you are receiving from them.

2. Take care of your health
• Follow the health care plan you and your team have worked out. Make sure you understand how to follow the plan.
• Set goals you can reach. Once you begin to see results, you and your team can discuss adding new goals.

3. Talk openly with your team
• If you are having trouble sticking with your care plan, tell your team about it.
• If you feel your care plan is not working, speak up.

4. Bring the following to each appointment:
• Insurance card
• Co-pay
• Driver's license
• Medications

The information contained in this publication is designed to answer questions frequently asked by our patients. We want to familiarize you with our policies and methods of practice. Our team of skilled medical professionals will be pleased to answer any questions you may have.

Forms
To ensure accuracy, forms that you present to be filled out by the doctor, (eg: sports, physicals, workers compensation), must be completed in your presence. Please schedule a time with us to help you complete your forms.

Referrals
Depending on your insurance, our referral department may schedule your visit to see a specialist or have an MRI/CT scan performed. Information regarding the appointment will be mailed to you or sent to your patient portal, unless it is urgent. Please do not call requesting information about your referral unless it has been longer than 7 days.

Prescriptions
We do not refill prescriptions over the phone. We believe in making sure that each medicine you take is exactly right for you and your unique situation. Please make an appointment with your provider for an appointment when you are in need of a refill.

Test results
For your convenience, most lab tests and diagnostic studies are performed on-site at CCMC. Your results will be made available to you through your online patient portal. Please note that we handle a large volume of phone calls and we ask that you call only if you have not heard from us more than 14 days after the tests were performed.