Cassopolis
Family Clinic Network
Our Family. Caring For Yours.

Patient Information Form

Patient information - Please fill out completely

How did you hear about us? { } Radio { } Newspaper { } Friend or Family Member { } Social Media { } Already a Patient

Patient Legal Name: _____ Preferred Name: _____ Preferred language: _____

Sex at Birth: { } Female { } Male Date of Birth:_____ SSN: _____

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

Home Phone: _____ Cell Phone: _____ Work: _____ Email: _____

OF People in Household: _____ Annual Household Income: $ _____

Marital Status:(check one) { } Single { } Married { } Divorced { } Widowed { } Legally Separated

Ethnicity (check one): Hispanic/Latino/Spanish: { } Mexican, including Mexican American & Chicano { } Puerto Rican { } Cuban { } Other Hispanic, Latino or Spanish origin { } Non-Hispanic/Latino { } Refused

Race (check all that apply):

{ } White { } Black/African American { } American Indian/Alaska Native { } Other { } Refused
Asian: { } Asian Indian { } Chinese { } Filipino { } Japanese { } Korean { } Vietnamese { } Other Asian
Native Hawaiian or Other Pacific Islander: { } Native Hawaiian { } Other Pacific Islander { } Guamanian or Chamorro { } Samoan

Housing: { } Own/Rent { } Government Housing { } Homeless { } Something Else { } Don't know { } Refused

Primary Care Physician: _____ Have you served in the Military? { } YES, Branch_____ { } NO

Do you have Advanced Directives/Living Will: { } Yes { } No; Do you have a Medical Power of Attorney: { } Yes { } No, *
If you answered Yes to either of these we need a copy for your health file.

Employment information

Occupation: _____ { } Farm Worker

Employer: _____ Address:_____ Phone:_____

Status: { } Full time { } Part time { } Retired (year)_____ { } Not Employed

Financial Responsibility- Parent, Legal Guardian, etc. If same as above, you may skip this section

Name of financially responsible person for patient:_____

Relationship: { } Parent { } Guardian { } Other_____

Date of Birth:_____ SSN: _____ Phone:_____ Cell: _____

Address/City/State/Zip: _____

Insurance Subscriber Information – Confirmed and entered into EHR previously

Insurance Subscriber Information: _____

Emergency Contact:

Name of Emergency Contact: _____ Phone:_____ Relationship: _____

The above information is true and accurate to the best of my knowledge.

_____ _____

Signature Date

CFCN Forms Updated: 3/2025

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Financial Policy

Insurance:

- Cassopolis Family Clinic Network (CFCN) is a provider for Medicare, Michigan Medicaid, Meridian, Medicaid HMOs, Breast & Cervical Cancer Control Program (BCCCP), and a number of other commercial insurance plans contracted through Lakeland Care Network, PHO. If you have commercial insurance that CFCN does not participate with, you are expected to pay the full charge at the time of service.
- It is your responsibility to know the coverage details of your insurance plan, including co-payments, deductibles, and provider participation.
- CFCN will bill participating insurance companies. Upon receipt of insurance payment(s), adjustments to your account will be made.
- Any services not covered by an insurance plan are your responsibility for payment.
- Balances after insurance companies have paid their part will be billed to you. The balance on your statement is due when the statement is issued. If you fail to make payment in a timely manner, your account will be sent to a collection agency.

Self-Pay/Sliding Fee Scale:

- If you are uninsured or under-insured you may apply for our Sliding Fee Scale Program, which is based on household size and gross income (less than 200% of the current federal poverty levels). At minimum, there is a $30.00 fee for medical office visits and $20.00 fee for preventative dental visits.
- Patients will need to complete an application and provide proof of income for all adults in the household, including social security benefits and child support for children in the home.

Payment:

- You are expected to pay all patient payments prior to being seen. This applies to commercial insurance, and any other insurances that has a co-pay.
- Payments can be made by cash, check, or credit/debit cards.
- CFCN charges a fee of $35.00 for any check returned to us for insufficient funds. This fee will be added to your account.
- Payment plans will be set up at the discretion of the Billing Department.

I understand my signature below indicates I have read and understand the above financial policy.

If your household income is less than the amount listed in this chart, you may qualify for financial assistance.

Patient's Name: _____

Responsible party (if not patient): _____

Signature: _____

Date: _____

*Discounts will only be applied to visits after application is approved.

Family Size	< 200% Federal Poverty Level
1	$31,300
2	$42,300
3	$53,300
4	$64,300
5	$75,300
6	$86,300

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COMMUNICATION PREFERENCE / CONSENT to TREAT FORM

Due to our concern for your confidentiality, we are asking that you sign a release to inform us of your communication preference.

Communication Preference: Check all that apply

{ } My Chart { } Phone { }: Home_____Work_____ Text { } appointment confirmation only { } Mail { } Email

_____YES, I give permission for office staff to call me to remind me of my appointment schedule and/or all test results. I understand the caller may leave a message that identifies them as calling from my physician's office.

_____NO, please do not call me at home or at work to notify of any type of medical information.

_____YES, I give my permission for office staff to leave detailed information regarding my appointment schedule, test results, prescriptions, or care on my answering machine:

_____YES, I give permission to the staff at my physician's office to share any or all information concerning my appointments, test results, prescriptions, or care with the following individual(s):

Name:_____ Phone: _____

Name:_____ Phone: _____

Name:_____ Phone: _____

_____I understand that if I say no to the above request I will be mailed a letter to notify me of test results or request me to call the office for more information.

Adult:
I,_____give my consent to be treated by Cassopolis Family Clinic Network providers. I understand that this consent gives permission to the health center's medical staff to perform reasonable and necessary medical examinations, testing, treatment and referrals on my behalf. I consent that some appointments may be conducted via telehealth which can be over the phone or through video/audio device.

Minor:
My child,_____is a patient of Cassopolis Family Clinic Network. I give permission for him/her to be treated by Cassopolis Family Clinic Network providers. I understand that this consent gives permission to the health center's medical staff to perform reasonable and necessary medical examinations, testing, treatment, and referrals on behalf of my child. I consent that some appointments may be conducted via telehealth which can be over the phone or through video/audio device.

_____ _____
Print Name of Patient/Parent/Legal Guardian Date

_____ _____
Signature of Patient/Parent/Legal Guardian Relationship to Patient

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PATIENT CENTERED MEDICAL HOME (PCMH)
PATIENT / PROVIDER PARTNERSHIP AGREEMENT

We are always looking for ways to better coordinate your healthcare needs. With this in mind, our health centers have moved towards the Patient Centered Medical Home (PCMH) care model.

As a PCMH, our team will look at how we can best coordinate your healthcare needs. This comprehensive and proactive way of managing your care is meant to improve the quality of your office visits as well as your overall health. Your primary care provider (PCP) will lead the team that will provide on-going care, with the goal of improving your health through a patient-provider relationship.

See benefits and expectations of PCMH are below:

Provider / Team Responsibilities:

- A provider directed healthcare team.
- Respect your privacy.
- Provide instructions on how to access our after-hours answering service to connect you with the on-call provider.
- Increased appointment availability, extended office hours and/or access to urgent/routine care services, as needed, including same-day appointments.
- Give you clear directions about medication and other treatments.
- Referrals and coordination of acre with trusted specialists, and community resources, as needed.
- Encourage you to play an active part in your own healthcare.
- Provide instructions on how to access your medical information via the patient portal:
    - Look up your medical information.
    - Stay in touch with your provider by a non-urgent electronic communication plan.
    - Request medication refills electronically.
- Set communication expectations regarding test results and other medical services.

Patient Responsibilities:

- Call us first with any medical problems unless it is an emergency.
- Know the names of your care team members.
- Ask questions, share your feelings and be an active participant in your healthcare discussions.
- Be honest about your medical history, symptoms, and other important information about your health, including any changes in your health and well-being.
- Set personal goals. Follow through with treatment plans as set up by care team including filling and taking medications as directed.
- Make healthy decisions about your daily habits and lifestyle.
- Keep appointments.
- Bring any test results done by other physicians back to your PCP's office.
- Participate with your care managers and health educators.
- End each visit with a clear understanding of expectations, treatment goals, and future plans.
- Bring your medications on each visit.

_____	_____	_____	_____
Patient Name (Print)	Patient/Guardian Signature	Date of Birth	Date

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Notice of Privacy Practices Receipt

I have received a copy of Cassopolis Family Clinic Network's **Notice of Privacy Practices**.

Please check the appropriate line:

_____I am the patient.

_____I am the parent or guardian of a minor._____ (patient name)

_____I have the Power of Attorney for_____ (patient name).

_____I refused a copy of the **Notice of Privacy Practices**.

Signature: _____ Date_____

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Notice of Privacy Practices
Form 7.20

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule. Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure. This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication. This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI*. This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI*. This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information*. This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability*. You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for

purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice. You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. * If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information. Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment. We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment. Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office. We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization. The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures. We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints. You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

Cassopolis Family Clinic Network, ATTN: Privacy Officer, 261 M 62, Cassopolis, MI 49031, Phone: (269) 445-3874