SMG OB/GYN Lake Lansing – St. Johns

New Patient Questionnaire

(Please Print Clearly and Fill Out Entirely)

Name: _____ Former/ Maiden Name: _____

Date of Birth: _____ Age: _____ Today's Date: _____

Current Gender Identity:

☐Male
☐Female
☐Transgender Male
☐Transgender Female
☐Gender Queer
☐Additional Category (Please Specify):
_____
☐Decline to Answer

Gender Assigned at Birth:

☐Male
☐Female
☐Other
☐Decline to Answer

What pronouns do you prefer we use when talking about/to you (check all that apply):

☐She/Her/Hers
☐He/Him/His
☐They/Them/Theirs
☐Other (Please Specify): _____

Do you identify as (check all that apply):

☐Straight
☐Gay
☐Lesbian
☐Bisexual
☐Other (Please Specify): _____

*Language: _____ Race: _____ Ethnicity: _____

*Do you have any barriers to communication? (please circle) Yes No Please List: _____

Reason for today's visit: _____

Primary Care provider: _____

Who referred you for this visit? _____

How did you hear about our practice? _____

Preferred pharmacy? _____

*Many questions are required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Thank You.

Advanced Directives

*Do you have a Durable Medical Power of Attorney? (Please circle) Yes No

If no, would you like an information packet today? (Please circle) Yes No

Allergies: Please list all allergies including medication, latex, foods, iodine, peanuts, eggs, shellfish etc.

Allergy	**Reaction**

Name: _____ Date of Birth: _____ Today's Date: _____

Medications: Please List ALL current medications including vitamins, herbs, and supplement's

Name of medication	**Dose**	**Amount taken**	**How often**
Ex: Vitamin D	*1,000 IU*	*1 tablet*	*Once daily*

Medical History: Do you have or have you had any of the following: Please check all that apply

( ) Anesthesia Problems	( ) Lung Problems
( ) Breast Problems	( ) Stomach Problems (Ulcer, GERD, etc.)
( ) Heavy/ Irregular Uterine Bleeding	( ) Eating Disorder
( ) Uterine Fibroids	( ) Gallbladder Disease
( ) Abnormal Pap Test / HPV	( ) Colon Problems (Diverticulitis, Colitis, Crohn's etc.)
( ) Pelvic Infection/Sexually Transmitted Disease	( ) Hepatitis / Liver Disease
( ) Vulvar Problems	( ) Kidney Disease
( ) Migraine Headaches	( ) Urinary Incontinence
( ) Epilepsy / Seizures	( ) Lupus
( ) Depression / Mental Illness	( ) Arthritis
( ) Thyroid Disease	( ) Previous Bone Fractures
( ) Diabetes	( ) Osteopenia / Osteoporosis
( ) High Blood Pressure	( ) Back Problems
( ) Stroke	( ) Blood Transfusions
( ) High Cholesterol	( ) Cancer: Type and Year?
( ) Heart Disease / Murmur	( ) Other Serious Illness (Please Describe)
( ) Blood Clot in Leg or Lungs	

Surgical History / Hospitalizations: Please list any surgeries or hospitalizations

Surgery/Hospitalization	**Year**	**Surgery/Hospitalization**	**Year**

Name: _____ Date of Birth: _____ Today's Date: _____

Family History: If you check any of the following, please list relationship of the relative(s)

Ex: Mother = M, Father = F, Sister = S, Brother = B, Maternal Grandmother – MGM, Maternal Grandfather = MGF, Paternal Grandmother = PGM, Paternal Grandfather = PGF, Maternal Aunt = MA, Paternal Aunt = PA, etc.

Problem	**Relationship**	**Problem**	**Relationship**
( ) *Breast Cancer		( ) High Cholesterol	
( ) *Ovarian Cancer		( ) Osteoporosis	
( ) *Uterine Cancer		( ) Emotional Issues	
( ) *Colon Cancer		( ) Mental Health Problems	
( ) Diabetes		( ) Alcoholism	
( ) High Blood Pressure		( ) Birth Defects	
( ) Heart Disease		( ) Other	

Personal and Social History: Please tell us about yourself. This information is intended to help us understand and meet the varied needs of the patients we care for.

How is your general health? ( ) Good ( ) Fair ( ) Poor		
Do you have regular dental check ups? ( ) Yes ( ) No	**Do you have your vision check regularly?** ( ) Yes ( ) No	
Do you have any hearing problems? ( ) Yes ( ) No	**Are you immunizations up to date?** ( ) Yes ( ) No	
Do you eat a healthy diet? ( ) Yes ( ) No	Do you have any weight concerns? ( ) Yes ( ) No	
Do you exercise regularly? ( ) Yes ( ) No	**Do you use seat belts?** ( ) Yes ( ) No	
*Do you do a monthly self breast exam? ( ) Yes ( ) No	Do you take calcium/ vitamin D? ( ) Yes ( ) No	
Have you ever smoked cigarettes? ( ) Yes ( ) No	Amount per day?	
Do you still smoke? ( ) Yes ( ) No	If no, what year did you quit?	If yes, how long have you smoked?
Do you use smokeless tobacco? ( ) Yes ( ) No	Are you interested in quiting? ( ) Yes ( ) No	
Do you drink alcohol? ( ) Yes ( ) No ( ) In recovery	If yes, amount per week?	
Type (ex. Wine, beer, liquor, etc.):	Are you interested in quitting? ( ) Yes ( ) No	
Do you use recreational drugs? ( ) Yes ( ) No ( ) In recovery	How Often?	Last use?
Type (Marijuana, cocaine, meth, etc.):	Are you interested in quitting? ( ) Yes ( ) No	
Have you ever been sexually active? ( ) Yes ( ) No	Birth control? ( ) Yes ( ) No Type:	

Name: _____ Date of Birth: _____ Today's Date: _____

Are you currently sexually active? ( ) Yes ( ) No	If yes, during the past year my partner(s) are (check all that apply): ( ) Monogomous relationship with 1 man ( ) Monogomous relationship with 1 woman ( ) Multiple male partners ( ) Multiple female partners ( ) Both male and female partners Other: _____

*Have you ever been verbally, emotionally, physically, or sexually abused?	( ) Yes ( ) No
Are you currently being verbally, emotionally, physically, or sexually abused?	( ) Yes ( ) No
Do you feel safe in your home?	( ) Yes ( ) No
Do you feel safe in your relationship(s)?	( ) Yes ( ) No

*__Marital Status:__ ( ) Single / Unmarried ( ) Married ( ) Civil Union ( ) Domestic Partnership, Living Together ( ) Partnered, Not Living Together ( ) Separated ( ) Divorced ( ) Widowed ( ) Other:

Living arrangements (ex. Alone, with spouse, children, etc.):

Are you employed? ( ) Yes ( ) No	If yes, where?	Type of work:
*Highest level of education completed?	*What is your best learning method? ( ) Verbal ( ) Written ( ) Visual	

Menstrual History:

Age of first period?	**Last menstrual period began?**
My periods are: Please check all that apply ( ) Regular ( ) Irregular ( ) Normal ( ) Heavy ( ) Painful ( ) Manageable / Tolerable ( ) Unmanageable, I want to talk about options for treatment	
Other Problems (Please List):	

Post- menopausal patients: Please check all that apply **( ) Not applicable**

( ) I have gone through menopause with no bleeding in the last year
( ) I have experienced some vaginal bleeding or spotting in the last year
( ) I am on hormone replacement therapy. List Type:
( ) I have taken hormones in the past and quit in (year):
( ) I am having trouble with hot flashes or night sweats and want to talk about treatment
( ) I have recently been experiencing a diminished sex drive

Contraception: Please check any that apply

( ) IUD	( ) Tubal Ligation	( ) Partner had vasectomy	( ) Birth control Pill
( ) Patch, ring or implant	( ) Condoms	( ) None	( ) Other
( ) Natural Family Planning			

Name: _____ Date of Birth: _____ Today's Date: _____

Gynecological History:

Have you ever had an abnormal pap test? ( ) Yes ( ) No	If yes, what year?
If yes, have you ever had a colposcopy? ( ) Yes ( ) No	If yes, what year?
Other treatment or procedures (ex. LEEP)?	What year?
Ever tested positive for a sexually transmitted disease(ex. Herpes, chlamydia, gonorrhea)?	( ) Yes ( ) No
If yes, list STD and Year:	

Pregnancy History:

Number of pregnancies		Number of live births		Number of premature births	
Number of abortions		Number of miscarriages		Number of living children	

Pregnancy History:

Birth #	Month / Year of Birth	Weight	Gender	Weeks Pregnant	Type of Delivery	Complications

******Last Menstrual Period Began?**_____

Name: _____ Date of Birth: _____ Today's Date: _____

Review of Systems: Have you been experiencing any of the following problems? **( ) No Problems**

General		
( ) Chills	( ) Fatigue	( ) Fever
( ) Hot flashes	( ) Night Sweats	( ) Sleep disturbance
( ) Recent weight loss_____pounds	( ) Recent weight gain_____ pounds	
Head, Eyes, Ears, Nose, and Throat		
( ) Ear pain	( ) Hearing Loss	( ) Ringing in ears
( ) Congestion	( ) Nasal discharge	( ) Nosebleeds
( ) Sore throat	( ) Dental problems	( ) Vision problems
Respiratory		
( ) Shortness of breath	( ) Wheezing	( ) Cough
Cardiovascular		
( ) Chest pain	( ) Swelling	( ) Irregular heartbeat
( ) Heart palpitations	( ) Rapid heart rate	
Gastrointestinal		
( ) Abdominal pain	( ) Bloody stools	( ) Constipation
( ) Diarrhea	( ) Nausea	( ) Vomiting
Gynecology		
( ) Pelvic pain	( ) Painful intercourse	( ) Vaginal discharge
( ) Painful periods	( ) Abnormal vaginal bleeding	( ) Nipple discharge
( ) Vulvar Itching	( ) Breast lump	( ) Genital ulcers
( ) Breast Pain	( ) Urinary frequency	( ) Painful urination
( ) Leaking Urine	( ) Nocturia (night urination)	( ) Urinary urgency
Musculoskeletal		
( ) Joint pain	( ) Joint stiffness	( ) Joint swelling
( ) Muscle pain	( ) Muscle weakness	( ) Limb pain / swelling
Dermatological		
( ) Acne	( ) Skin rash	( ) Mole changes
( ) Skin lesion		
Neurological		
( ) Dizziness	( ) Headaches	( ) Numbness or tingling
( ) Weakness		
Psychological		
( ) Anxiety	( ) Depression	( ) Decreased libido

Sparrow Medical Group OB/GYN Lake Lansing / St. Johns Today's Date: _____

Prenatal Diagnosis Screening Questionnaire

Patient:
Last Name: _____ First Name: _____ DOB: _____
Father of Baby:
Last Name: _____ First Name: _____ DOB: _____

Father's Occupation: _____ and Education: _____

1. How old will you be when the baby is due? _____

2. Have you been diagnosed with phenylketonuria? ___ Yes ___ No

3. Have you, the baby's father, or anyone in either family ever had the following?
   a. Down's Syndrome ___ Yes ___ No
   b. Spina Bifida or Open Spine Defect ___ Yes ___ No
   c. Hemophilia ___ Yes ___ No
   d. Muscular Dystrophy ___ Yes ___ No

4. Do you or the baby's father have any close relatives who have mental disabilities? ___ Yes ___ No
   If YES, describe: _____

5. Have you or the baby's father had a child born dead or alive with a birth defect not listed in question #3. ___ Yes ___ No
   If YES, describe: _____

6. Do you, the baby's father, or a close relative in either of your families have any inherited genetic or chromosomal diseases or disorders not listed above? ___ Yes ___ No
   If YES, describe: _____

7. Have you or a previous partner of this baby's father had 3 or more spontaneous pregnancy losses? ___ Yes ___ No
   If YES, describe: _____

8. What race do you consider yourself? _____

9. Are either you or the baby's father of Ashkenazi or Jewish heritage? ___ Yes ___ No
   If YES, have either of you been screened as carriers of Tay - Sachs disease? ___ Yes ___ No

10. If you or the baby's father is African- American, have you been tested as a carrier for sickle cell trait? ___ Yes ___ No
    If YES, describe: _____

11. If you or the baby's father is of Italian, Greek, or other Mediterranean heritage, have you been screened for anemia (Thalassemia)? ___ Yes ___ No
    If YES, describe: _____

12. If you or the baby's father are Caucasian or Ashkenazi Jewish, have you been screened as cystic fibrosis carriers? ___ Yes ___ No
    If YES, describe: _____

SMG OB/GYN
Lake Lansing & St. Johns

Fee Schedule for Obstetrical Patients

Full Routine Obstetric Care, Vaginal Delivery CPT Code = 59400
Full Routine Obstetric Care, Cesarean Delivery CPT Code = 59510
Antepartum Care Only >7 visits CPT Code= 59426
Vaginal Delivery Only CPT Code= 50409
VBAC Only (Vaginal birth after previous cesarean) CPT Code= 59612
Cesarean Section Only CPT Code= 59514
Post-Partum Care Only CPT Code=59430

Most insurance plans pay for routine pregnancy visits, delivery, and delivery follow-up (post-partum) care with a single payment, known as a "global OB package fee." What they consider as routine or normal, however, can vary from plan to plan.

Antepartum care is 13 visits. This includes the initial and routine subsequent history and physical exams, Patient's weight, blood pressure, fetal heart tones, and routine urinalysis. Beginning with visit 14, evaluation and management codes will be billed, and **there may be a copayment** depending on your insurance coverage.

Please Note:

- Medical management of problems that are not related to pregnancy such as bladder, vaginal or lung infections, allergies, rashes, etc.- are billed separately as an office visit from the global OB package, the same way it would be if you had gone to an urgent care center or to your Primary Care Physician. Insurance covers them, but separately, and **there may be a copayment**, depending on your insurance plan.
- High-risk conditions in pregnancy that require greater evaluation and treatment than covered by your insurance plan may also need to be billed separately from a global fee. Examples of these could be diabetes or high blood pressure.
- Any special testing or medications received during the course of your pregnancy care is an additional charge. These charges are billed to your insurance carrier at the time of testing. They may include: Amniocentesis, non-stress testing, ultrasound, and genetics testing.

- We perform a 20-week ultrasound to verify your due date, screen for fetal anatomy, and location of the placenta. We feel this is an important test and recommend that you have this done. However, if there is no medical indication for this, it will be billed as a routine screening. Some insurance companies may or may not pay for this. Please check with your insurance company, if there is a medical indication we will use that diagnosis. The cost for the ultrasound is approximately $ 765.

1651 W. Lake Lansing Road T 517.253.3910
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SMG OB/GYN
Lake Lansing & St. Johns

Please notify us at once of any changes in your insurance carrier, coverage, or policy numbers. Please check with your insurance regarding any prior authorization requirements for your hospital stay. Failure to do so could adversely affect your insurance benefits for both Physician and hospital charges.

Prior authorization requirements are the responsibility of the Patient for all insurance carries.

We DO NOT accept responsibility for this, regardless of what your insurance company may state.

Patient name (Please Print)	DOB
Patient's Signature	Date

Sometimes an insurance plan requires additional documentation to approve payment for something done that is beyond the global OB package fee. Occasionally, they may initially refuse payment for these charges, and pass them on to you. If you have any questions or problems with your bill, or wonder what you might be responsible for in the future, please talk with our billing specialist, at 517.364.7999 or 855.221.0336. She also has voice mail for your convenience. We want to give you not only the best medical care we can during your pregnancy, but also the best experience.

Sincerely,

The providers and staff of
SMG OB/GYN Lake Lansing
SMG OB/GYN St. Johns

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Lake Lansing & St. Johns

Ultrasound Payment Policy

Dear Patient:

We would like to advise you that most insurance companies will ONLY pay for one screening ultrasound (an ultrasound that is not ordered because of an identified problem) during a normal pregnancy. This policy is based on The American College of Obstetricians and Gynecologists (ACOG) practice Bulletin on Ultrasonography in Pregnancy and guidelines from the Society for Maternal-Fetal Medicine (SMFM). Any additional ultrasounds done, unless done for a very specific reason, may not be a covered benefit for you.

Under most insurance company guidelines additional ultrasounds ordered with a specific diagnosis should be a covered benefit, however, the final determination of coverage rests with your insurance carrier. If you are not sure what your insurance covers, please contact them.

****

My provider will discuss the reason(s) for requesting any additional ultrasound and advise me that it may or may not be a covered benefit for me under my insurance company's benefit policy. I may elect to have this test and understand that if my insurance company denies coverage that I will be financially responsible for it.

_____ _____

Patient name (Please Print) DOB

_____ _____

Patient's Signature Date

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SMG OB/GYN
Lake Lansing & St. Johns

Sparrow Hospital Obstetrics and Maternity Care Services
Agreement for Hospital Care

At Sparrow Hospital's Labor and Delivery Unit, we will do everything possible to give you the best care in your upcoming delivery. We provide:

- Obstetric care 24 hours a day, 365 days a year
- Experienced professionals that deliver thousands of babies every year
- A supportive environment during labor, birth, and after delivery

The doctors that **may** take care of you include: your personal Physician, other hospital Physicians, Resident Physicians, Nurses, Anesthesia Staff, and Pediatricians.

When you first come to the hospital, you will be seen by the Resident Physician who will evaluate you and call your personal physician group. If you are to be admitted to the hospital, a member of your personal physician group will be in charge of your care and present for your delivery. There will be times, though rare, when a member of your personal physician group may not be available for your delivery. If a member of your physician group is not available, Sparrow Hospital will provide another qualified obstetric physician to care for you.

The doctors that will provide your care may be male. There is no guarantee that a female Physician will deliver your child.

Your pregnancy and the birth of your baby will be one of the most exciting and emotional experiences of your lifetime. At Sparrow Hospital, we are honored to have the opportunity to share this wonderful event with you and your family. We are looking forward to meeting and caring for you!

I understand that the care provided to me by the staff of Sparrow Hospital Obstetrics and Maternity Care Services:

- May not always be the Physician that provided my prenatal care
- May include male Physicians

Patient name (Please Print)	DOB
Patient Signature	Date

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Sparrow Medical Group
OB/GYN Lake Lansing

Prenatal Infection Screening

Sparrow providers at SMG Lake Lansing OB/GYN follow guidelines and recommendations from The American College of Obstetricians and Gynecologist (ACOG) and the Michigan Department of Health and Human Services (MDHHS). That all pregnant patients undergo testing for HIV, Syphilis, Hepatitis B, Hepatitis C, Urine Drug Screen, Gonorrhea and Chlamydia with the first OB labs and again at 28 weeks. This is universal testing and not based on risk factors. If you don't do these tests during pregnancy, your pediatrician may recommend additional screening and treatments for your newborn.

_____ _____

I agree to the recommended screening. Date

_____ _____

I decline the recommended screening. Date

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Patient Registration Information

NOTE: Please complete this form in its entirety. This is a benefit to you to assure accurate billing on your behalf

(PLEASE PRINT LEGIBLY)

(PLEASE PRINT LEGIBLY) Last Name	**First Name**	**MI**	**DOB**

Mailing Address Apt/Lot Number City State Zip	Home Phone Number ( )
Email Address / Social Security Number	Cell Phone Number ( )
Patient Employer / Occupation	Work Phone Number ( )
Employer Address	**Work Status**: __ Self Employed __ Student __Full Time __ Part Time __Not Employed __ Retired (Retirement Date: _____)
Primary Care Physician:	

MEDICARE PATIENTS ONLY- Please Answer the Following Questions:

Are you eligible for black lung benefits? __ Yes __ No	Are you entitled to benefits through the dept. of veteran's affairs? __ Yes __ No
Are you on Medicare for an illness/injury that is due to a work-related accident/condition? __ Yes __ No	Are you eligible for Medicare based on disability? __ Yes __ No
Are you eligible for Medicare based on end- stage renal disease? __ Yes __ No	Are you or your spouse currently employed? __ Yes __ No

PRIMARY HEALTH INSURANCE & POLICY HOLDER INFORMATION – Insurance that will be billed first:

Name of Primary Insurance Company	Policy Number	Group Number

Policy Holder's Name	Relationship to Patient	Birthdate	Social Security Number

Policy Holder's Address (If different from Patient)	Home Phone Number ( )
Policy Holder's Employer Name and Address	Work Phone Number ( )

SECONDARY HEALTH INSURANCE & POLICY HOLDER INFORMATION – Insurance that will be billed second:

Name of Secondary Insurance Company	Policy Number	Group Number

Policy Holder's Name	Relationship to Patient	Birthdate	Social Security Number

Policy Holder's Address (If different from Patient)	Home Phone Number ( )
Policy Holder's Employer Name and Address	Work Phone Number ( )

EMERGENCY CONTACT INFORMATION- Please list a different phone number than the Patient

Name	Relationship	Home Phone Number ( )
Address		Work or Cell Phone Number ( )

GENERAL INFORMATION

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino __ Unknown __ Decline	Race: __ Asian __ Black or African American __ Hispanic __Native American __ Native Hawaiian or other Pacific Islander __ White __Other __ Unknown __Decline
Preferred Language: _____ Do you need an interpreter? __ Yes __ No	How do you prefer to be contacted for preventive reminders? __ MySparrow __ Mail __Phone __ Do not contact
Marital Status: ____ Single/Unmarried ___ Married ___ Civil Union ___ Divorced ___ Domestic Partnership, Living Together ___ Widowed ___ Legally Separated ___ Partnered, Not living Together ___ Other_____	Religion Preference:
Patient/ Guardian **Signature:**	Today's Date:

SMG OB/GYN
Lake Lansing & St. Johns

Missed Appointment Policy

In order to provide quality care to our Patients, improve access, and minimize wait time, our office has adopted the following policy regarding missed appointments.

I understand that if I should miss/cancel without 24 hours' notice a scheduled new patient appointment -or- miss/cancel with less than 24 hours' notice a scheduled appointment three (3) times in twelve (12) consecutive months, it will be necessary for me to make arrangements to receive my medical care elsewhere.

I further understand that the policy works as follows:

- A telephone call to cancel the appointment is required the business day prior to the scheduled appointment to avoid a missed appointment fee.
- If one appointment is missed, a reminder letter will be sent indicating that a scheduled appointment has been missed.
- If a second appointment is missed, another reminder letter will be sent, and a $25 fee will be generated.
- Upon failing to keep a third scheduled appointment, a certified letter will be sent indicating that three (3) scheduled appointments have been missed. A $50 fee will be generated. Within thirty (30) days, I will no longer be able to receive care at SMG OB/GYN Lake Lansing and will need to make arrangements to receive medical care from another source. I further understand that SMG OB/GYN Lake Lansing will assist me in finding another Physician through referrals, but that effective thirty (30) days from the date of the certified letter and with my primary Physician's consent, I will be removed from the active Patient list of SMG OB/GYN Lake Lansing.

Please Note: Parents and/or legal guardians will be held responsible for the appointments of minor children. The current fee for a missed appointment is $25 to $80. Your insurance company will not cover this fee. You will not be able to be seen without payment of this fee.

I have read the above policy in its entirety and fully understand that the above information relates to me and to my family members.

_____ _____

Patient name (Please Print) DOB

_____ _____

Patient's Signature Date

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SMG OB/GYN
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Payment Policy

Patient Name: _____ DOB: _____
(PLEASE PRINT)

We participate with many insurance companies, however it is your responsibility to verify that your insurance covers care provided at Sparrow and by the providers at SMG OB/GYN.

Your charges will be billed direct to your insurance company. Your deductibles and copays are due at the time of your appointment. If your insurance requires prior authorization, you will need to obtain this information from your Primary Care Physician (PCP).

As we strive to work together toward your good health we need to communicate a clear understanding of our payment policy. Full payment is due at the time of service if your insurance programs does not participate with SMG OB/GYN. Arrangements must be made with the billing department in advance for any payment made for less than payment in full. We bill for services received during your visit. This includes procedures, obstetrical services and surgeries. Please understand that because your contract is between you and your insurance company, we are not responsible to know specific information about individual contacts.

If you have any questions, please call the billing department:

Billing Customer Service
Phone: 517.364.7999
800.221.0336
Monday – Friday, 8 a.m. to 5 p.m.

Thank you for your cooperation.

Patient Signature: _____ Date: _____

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Sparrow

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Communication with Family & Friends Involved in My Care or Payment of My Care

Patient's Name:_____ Birth date:_____

Patients may allow family and friends, such as spouse, parent(s), significant others, guardians or others, to call and discuss medical information, request prescriptions, obtain vaccine information, request test results, pick-up completed forms (i.e., FMLA, sport physicals), and have messages left on answering machines or voicemail. They may also designate an individual to accompany them to medical appointments.

Completion of this form authorizes the release of the information identified above, to the individuals indicated below.

This authorization may be revoked at any time by submitting a written request.

1. Name: _____ Phone #: _____ Relationship: _____

   I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

   (Please check all that apply)

   - ☐ Receive information regarding appointments, including dates & times, and to pick up completed forms
   - ☐ Discuss medical care or concerns including test results, prescriptions, and vaccines
   - ☐ Accompany patient to appointments
   - ☐ Other (describe) _____

2. Name: _____ Phone #: _____ Relationship: _____

   I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

   (Please check all that apply)

   - ☐ Receive information regarding appointments, including dates & times, and to pick up completed forms
   - ☐ Discuss medical care or concerns including test results, prescriptions, and vaccines
   - ☐ Accompany patient to appointments
   - ☐ Other (describe) _____

3. Name: _____ Phone #: _____ Relationship: _____

   I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

   (Please check all that apply)

   - ☐ Receive information regarding appointments, including dates & times, and to pick up completed forms
   - ☐ Discuss medical care or concerns including test results, prescriptions, and vaccines
   - ☐ Accompany patient to appointments
   - ☐ Other (describe) _____

I understand that the individual receiving my information is not a health care provider or health plan covered by state or federal privacy laws and regulations and that the information described above may no longer be protected by those laws and regulations.

I understand that I may revoke or change this authorization, in writing, at any time, by sending notification to the Sparrow Health Information Management at the address above.

_____ _____

Signature of patient Date & Time