West Michigan FAMILY MEDICINE
616-785-3883
1550 3 Mile Rd NW, Suite A
Grand Rapids, MI 49544
WestMichiganFamilyMedicine.com

Adult Health History Form (Ages 18 and Older)

Full Name: _____

Date of Birth: _____ **Age:** _____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

Phone: _____ **Email:** _____

Occupation: _____

Emergency Contact Name & Relationship: _____

Phone: _____

Medical History

Please check if you have ever been diagnosed with or currently have any of the following:

Conditions	Yes	No
High Blood Pressure	☐	☐
Diabetes	☐	☐
High Cholesterol	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Asthma / COPD	☐	☐
Thyroid Problems	☐	☐
Gastrointestinal Issues	☐	☐
Cancer (Type: _____)	☐	☐
Depression / Anxiety	☐	☐
Arthritis	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Blood Clots	☐	☐
Sexually Transmitted Infections (Gonorrhea, Herpes, Syphilis, etc.)	☐	☐
Mumps / Measles	☐	☐
Chickenpox / Shingles	☐	☐
Other: _____	☐	☐

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Female Concerns

Age when you had your first period: _____

Average number of days of flow: _____

Length of time between periods: _____

Number of pregnancies: _____ Number of lives birth: _____

Number of miscarriages: _____ Number of abortions: _____

Number of living children: _____

Date of last Pap smear: _____

Have you ever had an abnormal Pap smear? **Yes** ☐ **No** ☐

Male Concerns

Check if you have had problems with the following:

Testicular Pain or Swelling ☐ Prostate Issues/Concerns ☐ Urination Trouble ☐

Surgical History

Please list all surgeries and approximate year:

Past Hospitalizations/Accidents

Please list all surgeries and approximate year:

Allergies

☐ No known allergies

☐ Allergies (list below):

Medication / Substance: _____ **Reaction:** _____

Medication / Substance: _____ **Reaction:** _____

Current Medications

Please list all prescription, over-the-counter, and supplements:

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Family History

Check if any family members have had the following:

Condition	Mother	Father	Sibling	Grandparent
Heart Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Cancer (Type: _____)	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Mental Health Disorder	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current — **Type:** _____ Packs/day: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Regular — Amount per week: _____

Drug Use: ☐ No ☐ Yes — Type: _____ Frequency: _____

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks — Amount/day: _____

Exercise: ☐ Rarely ☐ 1–2x/week ☐ 3+ times/week

Diet: ☐ Balanced ☐ High Fat ☐ High Carb ☐ Vegetarian ☐ Other: _____

Sleep: Average hours per night: _____

Sexually Active: ☐ Yes ☐ No

Birth Control / Protection: ☐ None ☐ Condom ☐ Pill ☐ Other: _____

Review of Systems

Please check any current symptoms you are experiencing:

☐ Fever ☐ Weight change ☐ Fatigue ☐ Chest pain ☐ Shortness of breath ☐ Cough

☐ Abdominal pain ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Urinary issues

☐ Headaches ☐ Dizziness ☐ Depression ☐ Anxiety ☐ Rash ☐ Joint pain

☐ Other: _____

Additional Information

Is there anything else you would like your provider to know?

Signature: _____ **Printed Name**: _____

Date: _____

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General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, and/or diagnostic procedures to be used/performed so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature, even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.
I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, etc.), and/or other health care providers to perform reasonable and necessary medical examinations, testing, and treatments for the condition in which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Authorization and Release: I authorize the release of any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such care to third party and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize West Michigan Family Medicine, PC physicians to treat my child or myself. I agree that West Michigan Family Medicine, PC can contact me by any telephone associated with my account. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device. West Michigan Family Medicine, PC complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Printed Name:_____

Date of Birth: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Relationship to Patient: _____

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Office Policies

Our office and phone hours are Monday – Thursday from 8:00 AM to 4:00 PM, and Friday from 8:30 AM – 4:00 PM. We are closed for lunch from 12:30 PM to 1:30 PM.

Payment for services is expected at the time of service. If you have a co-pay, this will be collected at registration. It is the patient's responsibility to check with their insurance company about coverage of any visit, test, procedure, etc. We accept cash, check, Visa, Mastercard, Discover, and American Express.

A child under the age of 18 will not be seen without a legal guardian. If you absolutely cannot accompany your child to the appointment, you must provide written consent for us to treat him/her.

Prescription refills will be completed within 48 business hours. We recommend you call the office one week before your prescription expires.

We request a 24-hour notice if you must change or cancel your appointment for any reason. **IF A 24-HOUR NOTICE IS NOT GIVEN, YOU WILL BE CHARGED $40.00 FOR AN OFFICE VISIT OR $60.00 FOR A PHYSICAL, EXTENDED VISIT, OR PROCEDURE.** Missing three scheduled appointments without notifying us in advance will result in a discharge from our practice. If you arrive late for your appointment, you may be asked to reschedule. For **new patients**, missing two scheduled appointments without notifying us in advance will result in discharge from our practice. This also includes arriving 5-10 or more minutes late to a scheduled appointment.

Patients requesting a form to be completed by the physician will be charged a fee. The dollar amount will be determined by the physician.

Our after-hour call service has increased their rate per patient phone call to $25 per call. If excessive or inappropriate use of the service is happening, the charges will be passed on to the patient.

I acknowledge that I have received and read the patient information from.

Patient Signature: _____ Printed Name:_____

Date of Birth: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Relationship to Patient: _____

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Patient Acknowlegement of Financial Responsibility

This form explains your financial responsibility for medical services received at our office. Please read carefully and sign below to acknowledge your understanding and agreement.

Insurance and Payment Policy

- I understand that it is my responsibility to provide accurate and current insurance information for each visit.
- I authorize the release of medical information necessary to process my claims.
- I understand that my insurance policy is a contract between myself and my insurance company, not between my insurance company and this practice.
- I am responsible for verifying my coverage, benefits, and any referral or authorization requirements prior to my visit.

Financial Responsibility

- I understand that I am financially responsible for all charges not covered by my insurance plan, including copayments, coinsurance, deductibles, and non-covered services.
- Copayments are due at the time of service.
- If I have a deductible plan, I agree to pay a **$50.00 deposit toward my visit** at check-in.
- I will be billed for any remaining balance after my insurance has processed my claim, and payment is due upon receipt of the statement.
- Balances that remain unpaid after 90 days may be subject to collections.

Missed Appointments and Late Cancellations

- I understand that appointments did not cancel at least 24 hours in advance may result in a missed appointment fee.
- Repeated missed or late-canceled appointments may lead to dismissal from the practice.

Returned Checks / Payment Plans

- A service fee will apply to all returned checks.
- If I am unable to pay my balance in full, I agree to contact the billing department to arrange a payment plan.

Assignment of Benefits

I authorize payment of medical benefits directly to this office for services rendered.

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I have read and understand this Financial Responsibility Policy. I agree to be financially responsible for all charges incurred as outlined above.

Patient Signature: _____ Printed Name:_____

Date of Birth: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Relationship to Patient: _____

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NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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

Protected Health Information, PHI, is maintained as a written and/or electronic record of your contacts or visit for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (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 required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This notice describes your right to access and control your PHI. It also describes how we follow applicable rules, use, and disclose 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.

You have the right to:

Get a copy of your medical record

You can ask to see or get a copy of your medical record and other health information we have about you. We will provide a copy or a summary within 30 days of your request. A reasonable fee may apply.

Ask us to correct your medical record

You can ask us to correct health information you think is incorrect or incomplete. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, but we will comply when possible.

Get a list of those with whom we’ve shared your information

You can ask for a list (an “accounting”) of the times we’ve shared your health information for six years prior to the date you ask.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you received it electronically.

Choose someone to act for you

If you have given someone medical power of attorney or have a legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting:
West Michigan Family Medicine – Privacy Manager
Phone: 616-+785-3883
Address: 1550 3 Mile Rd NW, Suite A Walker, MI 49544

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights at www.hhs.gov/ocr/privacy/hipaa/complaints/.
We will not retaliate against you for filing a complaint.

Your Choices

You have some choices in the way we use and share information:

In these cases, you have the right to tell us to limit or not share your information:

- Marketing or fundraising communications
- Sales of your information
- Sharing information with your family, close friends, or others involved in your care

If you cannot tell us your preference (for example, if you are unconscious), we may share your information if we believe it is in your best interest or necessary for your care or safety.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- For treatment
  We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- For payment
  We can use and share your health information to bill and receive payment from health plans or other entities.
  Example: We give information about your treatment to your insurance plan so it will pay for your services.
- For healthcare operations
  We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information to review the quality of our services.

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Other Ways We May Use or Share Your Information

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We must meet certain conditions before we share your information for these purposes.

- Public health and safety issues (disease prevention, recalls, reporting abuse or neglect)
- Research
- Compliance with law enforcement or legal requests
- Organ and tissue donation requests
- Workers' compensation, law enforcement, and government functions
- Responding to lawsuits and legal actions

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information (PHI).
We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and provide you with a copy upon request.
We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time by letting us know in writing.

Changes to This Notice

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website (if applicable).

Acknowledgement of Notice of Privacy Practices

I, _____, understand that I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal healthcare operations, such as quality assessments and accreditations.

Patient Signature: _____ Printed Name:_____

Date of Birth: _____ Date: _____

Parent/Guardian Signature and Relationship (if applicable):_____

Effective Date: 10/9/2025 Publication Date: 10/9/2025

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HIPAA Authorization for Release of Health Information

Patient Information

Patient Name: _____ **Date of Birth:** _____

Phone Number: _____

Address: _____

Authorization

I hereby authorize West Michigan Family Medicine and its staff to release or discuss my medical and billing information with the following individual(s):

Name	Relationship to Patient	Phone Number	Information Allowed (check all that apply):
_____	_____	_____	☐ Medical ☐ Billing ☐ Scheduling ☐ All
_____	_____	_____	☐ Medical ☐ Billing ☐ Scheduling ☐ All
_____	_____	_____	☐ Medical ☐ Billing ☐ Scheduling ☐ All

Information to Be Released

This authorization allows verbal and/or written communication regarding:

☐ Medical care and treatment

☐ Lab results and diagnostic tests

☐ Appointments and scheduling

☐ Billing and insurance matters

☐ Other (please specify): _____

Expiration and Revocation

This authorization will expire one (1) year from the date signed below unless otherwise specified.

I understand that I may revoke this authorization at any time by submitting a written request to the office, except to the extent that action has already been taken in reliance on this authorization.

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Patient Rights

- I understand that my treatment, payment, or eligibility for benefits will not be conditioned on my signing this authorization.
- I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.
- I have the right to inspect or copy the information being disclosed.

Patient Signature: _____ Printed Name:_____

Date of Birth: _____ Date: _____

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We are your **Patient Centered Medical Home**, focused on you and your relationship with your physician. Our partnership with you means that you will always have active involvement in your health care plan.

We as your physician and health care team will:

- Provide you with comprehensive, compassionate, and effective care.
- Provide you with the opportunity to communicate your concerns about your health and the care you receive.
- Assist in coordinating your care with other qualified physicians and professionals, as needed.
- Respect your privacy. Your medical information will not be shared with anyone unless you give us permission, or it is required by law.
- Provide care that meets your needs and fits with your goals and values.
- Explain your health and illnesses in a way you can understand.
- Provide care that is based on quality and safety.
- Provide same-day appointments and 24-hour access to medical care.
- Provide information regarding other resources available to you outside of this office, such as community agencies and services.

We ask that you participate and let us help you:

- Provide us with the information we need to help you obtain your personal goals.
- Do your best to follow a healthy lifestyle and be involved in understanding and managing your health care. Be sure to let us know if you are unable to follow the advice of your health care team.
- Tell us about any illnesses, hospitalizations, medications, and other health related matters.
- Ask us of any health care services you have received outside of this office such as eye exams, foot exams, oral care, injections, immunizations, etc.
- Prepare an Advance Directive and be certain that we have it on file.
- Learn about your insurance so you know what is covered.
- Give us feedback so we can improve our services.
- Feel free to talk to us. The more we know about how you feel, the better we can help you.

Establishing a partnership between the patient and the health care team, along with family members and patient advocates, allows decisions to be made that are respectful of the physician's knowledge and experience, while making sure the patient's wants, needs, and personal preferences are met. The patient is supported by the knowledge that they can make decisions and participate in their own care.

Our offices hours are Monday – Thursday from 8:00 AM to 4:00 PM, and Friday from 8:30 AM to 4:00 PM. Our office phone number is 616-785-3883. Our fax number is 616-785-1982. Our after-hours emergency phone number is 616-391-9903. Our billing department phone number is 616-250-5343. Please visit us online at www.westmichiganfamilymedicine.com to find more information regarding our practice.

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