Welcome to the Genetic Risk Assessment Clinic

****If the forms are not completed when you arrive for your appointment it will have to be rescheduled.****

You are scheduled on _________________ at _________________ to discuss genetic testing with our Nurse Practitioner.

Please arrive no later than your scheduled appointment time. Due to the group counseling atmosphere we will have to reschedule any late arrivals. Thank you for your consideration.

This appointment will include an informational session with other patients. Your personal information WILL NOT be discussed during this time. At the conclusion of the session you will be moved to an exam room to discuss your personal information with the Nurse Practitioner individually. For a comprehensive evaluation it is extremely helpful to have as much information as about you and your family’s cancer history as possible. Please allow approximately 2 hours for this appointment.

Enclosed you will find detailed patient history forms. Please take the time to complete these forms so they are completed when you arrive for your appointment. This information is essential to complete your Genetic Risk Assessment.

Insurance coverage and questions will be discussed at your appointment. There will be no testing done without checking insurance coverage.

Our office is located in the Edye Building at 4660 S Hagadorn Rd Suite 600 East Lansing, MI 48823. Parking is free. If you have any questions prior to your appointment time, please feel free to contact us at 517-267-2460 or toll free 888-451-2909.

We are looking forward to meeting you!
Genetic Risk Assessment Family History Form

Name________________________________________Date of Birth__________________________________________

Do you have a personal history of cancer: Yes ☐ No ☐ If yes: At what age were you diagnosed_____ What type of cancer: ________________________________

Has any family member had genetic testing: Yes ☐ No ☐ If yes, which relative and results of testing:__________________

Children

<table>
<thead>
<tr>
<th>Name</th>
<th>Current Age (if deceased please indicate age at death)</th>
<th>Cancer history? Please indicate what type.</th>
<th>If cancer history, age at diagnosis</th>
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</thead>
<tbody>
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<td>☐ Check if Deceased ☐ check if none</td>
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Siblings (brothers and sisters):

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<tr>
<th>Name</th>
<th>Current Age (if deceased please indicate age at death)</th>
<th>Cancer history? Please indicate what type.</th>
<th>If cancer history, age at diagnosis</th>
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<td>Name</td>
<td>Current Age (if deceased please indicate age at death)</td>
<td>Cancer history? Please indicate what type</td>
<td>If cancer history, age at diagnosis</td>
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<tr>
<td>Mom</td>
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<tr>
<td>Mom's Siblings: Her brothers and sisters-your aunts and uncles</td>
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<tr>
<td>Mom's parents: Your grandparents</td>
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<td>Maternal Grandmother</td>
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<tr>
<td>Maternal Grandfather</td>
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- Check if Deceased
- Check if none
Father's History (*dad's side)*:

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<tr>
<th>Name</th>
<th>Current Age (if deceased please indicate age at death)</th>
<th>Cancer history? Please indicate what type</th>
<th>If cancer history, age at diagnosis</th>
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<tbody>
<tr>
<td>Dad</td>
<td>□ Check if Deceased</td>
<td>□ check if none</td>
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<tr>
<td>Dad's Siblings: His brothers and sisters-your aunts and uncles</td>
<td>Current Age (if deceased please indicate age at death)</td>
<td>Cancer history? Please indicate what type</td>
<td>If cancer history, age at diagnosis</td>
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Dad's parents: Your grandparents

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<tr>
<th>Name</th>
<th>Current Age (if deceased please indicate age at death)</th>
<th>Cancer history? Please indicate what type</th>
<th>If cancer history, age at diagnosis</th>
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<tbody>
<tr>
<td>Paternal Grandmother</td>
<td>□ Check if Deceased</td>
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<td>Paternal Grandfather</td>
<td>□ Check if Deceased</td>
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</tbody>
</table>
### Additional Family members not listed above that have cancer. Please include cousins, great aunts/uncles:

<table>
<thead>
<tr>
<th>Name</th>
<th>Paternal or maternal</th>
<th>How are they related? I.e. great-aunt, cousin etc.</th>
<th>Current Age (if deceased please indicate age at death)</th>
<th>Cancer history? Please indicate what type</th>
<th>If cancer history, age at diagnosis</th>
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</table>

### Family Ancestry:
What is your family ancestry?

Paternal:__________________________________________Do you have any Ashkenazi Jewish ancestry? □ Yes □ No

Maternal:_________________________________________ Do you have any Ashkenazi Jewish ancestry? □ Yes □ No
New Patient Registration

Name (Last, First, Middle) __________________________  Date of Birth ________________

Social Security# __________________________  Sex M / F  Marital Status M / S / D / W

Race __________________________  Ethnicity __________________________  Preferred Language __________________________

Address __________________________  Home Phone __________________________

City, State, Zip Code __________________________  Cell Phone __________________________

Employer __________________________  Work Phone __________________________

Email Address __________________________

Primary Care Dr __________________________  Referring Dr __________________________

Address __________________________  Address __________________________

Phone ______________  Fax ______________  Phone ______________  Fax ______________

Are you here as a result of an injury? Y / N  If yes, Date of Injury __________________________

Type of Injury (Please Circle) WORK  AUTO  OTHER __________________________

Is this visit a follow-up from a recent surgery? Y / N  Date of Surgery __________________________

Primary Insurance __________________________

Secondary Insurance __________________________

Policy Holders Name __________________________

Address __________________________

Relationship __________________________  DOB ______________

Policy Holders Name __________________________

Address __________________________

Relationship __________________________  DOB ______________

*Co-pay amount or percentage per office visit __________________________

Emergency Contact:

Name __________________________  Relationship __________________________  Phone __________________________

If patient is a minor, please fill out the following:

Mother’s Name __________________________  Father’s Name __________________________

Address __________________________

Address __________________________

Phone ______________  DOB ______________  Phone ______________  DOB ______________

Patient resides with: Both parents  Mother  Father  Other __________________________
MSU DEPARTMENT OF SURGERY
PATIENT PROFILE

Legal Name: __________________________ Name You Prefer: __________________________
Birthdate: ________________ Age: _______ Ht: _______ Wt: _______ Occupation: ________________
Race: __________________________ Language: ________________ Method of Contact: __________________________
Smoking/Tobacco Use: Current______ Quit______ Never______
Second Hand Smoke: Never______ Current______ Past______
Smoking Cessation Counseling Given: Yes______ No______ Deferred______
Current Pain Level (1-10) ________ Where ________________ Referring Doctor: __________________________
Primary Doctor: __________________________
Reason for Visit Today: __________________________

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES TO MEDICATIONS/FOOD/LATEX/OTHER:

PLEASE LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE DATES):

PLEASE CIRCLE ANY OF THE FOLLOWING DIAGNOSES THAT APPLY:
- Anemia
- CVA/Stroke
- Emphysema
- Myocardial Infarction
- Anesthesia Complications
- Coronary Heart Disease
- GERD
- Mitral Valve Prolapse
- Antibiotic use prior to procedures
- Chronic Renal Failure
- Hepatitis A B C
- Osteo/Rheumatoid Arthritis
- Asthma
- Cirrhosis
- High Cholesterol
- Osteoporosis
- Atrial Fibrillation
- Colon Cancer
- High Blood Pressure
- Pancreatitis
- Blood Transfusions
- Crohn’s Disease
- Hypothyroidism
- Peripheral Vascular Disease
- Breast Cancer
- Deep Vein Thrombosis
- Hyperthyroidism
- Pulmonary Embolism
- Breast Disease
- Depression
- IBS
- Seizure Disorder
- COPD
- Diabetes-Type I
- Kidney Disease
- Tuberculosis
- Diabetes Type-II
- Kidney Stone
- Valvular Heart Disease
- Varicose Veins/Phlebitis
- Diverticulitis
- Morbid Obesity
- MRSA
- VRE
- Type of Cancer(s) __________________________

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING BIRTH CONTROL AND “OVER THE COUNTER” MEDICATIONS OF ASPIRIN, TYLENOL, VITAMINS, ETC. (INCLUDE DOSAGE)

Family History (Blood Relatives only)
CANCER: Breast, Cervical, Colon, Liver, Lung, Ovarian, Pancreatic, Prostate, Skin, Melanoma Coronary, Heart Disease, Colon Polyps, Thyroid Disease

7/21/14 VERSION NEW PT PPWK
### GENERAL
- No concerns
- **Fever**
- **Fatigue**
- **Anemia**
- **Weight loss**
- **Loss of Appetite**

### HEAD/EYE/EAR/NOSE/THROAT
- **No concerns**
- **Decreased hearing**
- **Sore throat**
- **Neck swelling**
- **Thyroid problems**
- **Mandibular/jaw fracture**
- **Goiter**
- **Nasal fracture**
- **Dentures**
- **Seizures**
- **Mandibular/jaw fracture**
- **Goiter**
- **Nasal fracture**
- **Dentures**
- **Seizures**
- **Frequent headaches**
- **Glucoma**
- **Cataracts**
- **Blur red vision**
- **Eye injury**

### STOMACH/DIGESTION
- **No concerns**
- **Abdominal pain**
- **Nausea**
- **Vomiting**
- **Diarrhea**
- **Constipation**
- **Recent weight loss**
- **Change in bowel habits**
- **Black tarry stools**
- **Blood in stools**
- **Hepatitis**
- **Gas/Bloating**
- **Indigestion/Heartburn**
- **Difficulty swallowing**
- **Painful swallowing**

### BREAST
- **No concerns**
- **Left breast lump**
- **Right breast lump**
- **Nipple discharge**
- **Bloody nipple discharge**
- **Breast pain**
- **Abnormal mammogram**
- **Breast enlargement**
- **Nipple inversion**

### HEART/CIRCULATION
- **No concerns**
- **Chest pain**
- **Irregular heart beat**
- **Fainting/Blackout spells**
- **Heart surgery**
- **Swelling of arms or legs**
- **Stents**
- **History of heart attack**

### PULMONARY/LUNGS
- **No concerns**
- **Cough**
- **Shortness of breath**
- **Blood in sputum**
- **Wheezing**
- **Pain with breathing**
- **Use of oxygen**
- **COPD**
- **Asthma**

### URINARY
- **No concerns**
- **Incontinence**
- **Painful urination**
- **Blood in urine**
- **Urinary frequency**
- **Urinary hesitancy**
- **Nocturia**

### FEMALE ONLY
- **Vaginal discharge**
- **Abnormal vaginal bleeding**
- **Pelvic pain**
- **Pregnancy**
- **Menopause**
- **HRT**
- **# of pregnancies**
- **# of live births**
- **Last menstrual period**

### MALE ONLY
- **No concerns**
- **Abnormal discharge**
- **Erectile dysfunction**

### WOUND
- **No concerns**
- **Redness**
- **Discharge**
- **Pain**
- **Opening of wound**
- **Purulent discharge**
- **Bleeding from wound**

### SKIN
- **No concerns**
- **Suspicious lesions**
- **New skin lesions**
- **Rash**
- **Changing moles**
- **History of Cancer**
- **Itching**

### NEUROLOGICAL
- **No concerns**
- **Paralysis**
- **Parathesias**
- **Seizures**
- **Dizziness**
- **Frequent headaches**
- **Head injury**
- **History of Alzheimer’s**
- **History of stroke**

### PSYCHOLOGICAL
- **No concerns**
- **Depression**
- **Anxiety**
- **Memory loss**
- **Thoughts of suicide**
- **Hallucinations**
- **Claustrophobia**

### ENDOCRINE
- **No concerns**
- **Heat intolerance**
- **Cold intolerance**
- **Unusual weight change**
- **Exposure to radiation**
- **Hair loss**

### HEMATOLOGY
- **No concerns**
- **Abnormal bruising or bleeding**
- **Anemia**
- **Enlarged lymph nodes**
- **Anticoagulation**
- **Transfusion**

### MUSCULOSKELETAL
- **No concerns**
- **Back pain**
- **Sciatica**
- **Arthritis**

### OTHER
- **No concerns**
- **Stoma**
- **Redness**
- **Pain**
- **Discharge**
- **Vascular access**
- **Redness**
- **Pain**
- **Discharge**

### SOCIAL HISTORY

<table>
<thead>
<tr>
<th>Tobacco use:</th>
<th>Current</th>
<th>Quit</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>Year started:</td>
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<tr>
<td>How much per day:</td>
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</tr>
</tbody>
</table>

| Second hand smoke: | YES | NO |
| Alcohol use: | YES | NO |
| Use of cocaine, marijuana, heroin, steroids: | YES | NO |
| History of treatment for substance abuse: | YES | NO |
| Hit, Slapped, or Kicked with in the past year: | YES | NO |
| Sexually abused within the past year: | YES | NO |
| Religious beliefs affecting care: | YES | NO |
Patient Name: ___________________________ Date of Birth: ___________________________

What breast concerns are you being seen for today? ___________________________

Describe: ___________________________

FAMILY BREAST CANCER HISTORY

A: Is there a history of breast cancer in your blood related family? (If yes, complete section below)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Grandmother(s)</td>
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<tr>
<td>Mother</td>
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<td>Sister(s)</td>
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<td>Daughter(s)</td>
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<tr>
<td>Aunt(s)</td>
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<td>Father</td>
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<td>Brother(s)</td>
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<td>Son(s)</td>
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<td>Uncle(s)</td>
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<tr>
<td>Grandfather(s)</td>
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</tbody>
</table>

TREATMENT RECEIVED

CIRCLE ONE

Alive/Deceased

AGE AT DIAGNOSIS

PAST BREAST HISTORY

A. Do you have any history of non-cancerous breast problems? (i.e. fibrocystic changes, mastitis)

YES NO

If yes, describe: ___________________________

B. Have you had any procedures/operations or needle biopsies on your breast(s)? (If yes, please complete)

<table>
<thead>
<tr>
<th>PROCEDURE DATE</th>
<th>BREAST</th>
<th>TYPE OF OPERATION</th>
<th>HOSPITAL CITY/STATE</th>
<th>SURGEON</th>
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<td>R / L</td>
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</table>

C. Have ever been diagnosed with breast cancer? (If yes, check ALL treatments below that apply)

YES NO

Mastectomy (surgical removal of breast)

Lumpectomy or Wide Excision (removal of lump from breast only)

Chemotherapy

Other

D. Have you ever received radiation (cobalt) treatments to face, tonsils, skin, thymus, chest for cancer?

YES NO

If yes, How much? ___________________________ How long? ___________________________

GYNECOLOGICAL HISTORY

A. Age you began menstruating? ________ Stopped? ________ Naturally? ________ Due to surgery? ________

B. Have you had surgery to remove your uterus (womb)? YES NO

C. Any surgery to remove your ovaries? YES NO

D. Number of pregnancies ________ Number of completed deliveries ________ Age at first delivery ______

E. Have you ever taken estrogens, progesterone or hormonal pills? ________ Age? ________ How long? ______


CONCERNS ABOUT BREAST CANCER

Please use the back of this form to tell us anything not covered above that could help us with your care.

Patient Signature: ___________________________  Dr/Nurse Signature: ___________________________  Date: ___________
MICHIGAN STATE UNIVERSITY
DEPARTMENT OF SURGERY

We are pleased to offer you a wide range of services to meet your surgical needs. Our team of surgeons, residents, nurses and staff provide exceptional health care in a comfortable and caring environment. We are committed to providing you the highest quality of compassionate surgical care. If you choose to have a procedure, we will work with your schedule to make arrangements. If your introduction to us is for an emergency or acute problem we are available every day and night of the year. Our team is dedicated to working with you, your family and your personal physician to personally and professionally provide your surgical care.

As our patient, you will have access to our clinical expertise. Our surgeons are faculty of Michigan State University College of Human Medicine and belong to the MSU Health Team, a large group of primary care and specialist physicians. Through collaboration with our colleagues, community physicians and our affiliation with area teaching hospitals, our surgeons provide a comprehensive approach to meet your health care needs. Our commitment to you includes the following:

- Our team will work together and we will offer consultation among our surgeons so you may benefit from our group’s expertise.
- Patient education is an important part of our practice. As experienced teachers, we are committed to providing you truthful information and the support you need to make informed decisions about your health care.
- As educators of the next generation of surgeons, it is our obligation and commitment to you to apply the most advanced scientific knowledge and surgical standards available for your benefit.

If we can be of any further assistance to you, please contact our office at (517) 267-2460. We are available Monday through Friday 8:00am to 4:45pm. Thank you for choosing MSU Surgery for your surgical care.

PLEASE CONTINUE ON BACK PAGE
Your surgical team has many health care providers involved in your care. Your **Attending Surgeon**, as leader of the team, will discuss your medical and surgical concerns, options and recommended plan. Each surgeon in our Department is Board Certified or Board Eligible. This Board certification is another assurance that you are receiving care from the most qualified individuals. As faculty of MSU, our surgeons are actively involved in the education of surgical residents and medical students. **Surgical Residents** are licensed physicians who have a college degree and a medical degree. They have completed advanced education from an accredited medical school and are studying to become surgeons. **Medical Students** are individuals who have completed college, are enrolled in medical school and are training to become physicians. Both residents and students provide aspects of your care, but always under direction of your attending surgeon.

The information below should help to clarify medical titles and level of education.

<table>
<thead>
<tr>
<th>TITLE TRAINING</th>
<th>LEVEL OF PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician</td>
<td>Medical degree with completion of advanced training in surgery</td>
</tr>
<tr>
<td>Chief Resident</td>
<td>Medical degree in last year of advanced training in surgery</td>
</tr>
<tr>
<td>Resident</td>
<td>Medical degree in 2\textsuperscript{nd}-4\textsuperscript{th} year of advanced training in surgery</td>
</tr>
<tr>
<td>Intern</td>
<td>Medical degree in 1\textsuperscript{st} year of advanced training in surgery</td>
</tr>
<tr>
<td>Medical Student</td>
<td>College degree (enrolled in medical school)</td>
</tr>
<tr>
<td>Pre Medical Student</td>
<td>No college degree (enrolled in college)</td>
</tr>
</tbody>
</table>
Patient Name: ___________________________ Date of Birth ________________
(Please Print - Last Name, First Name, Middle Initial)

PAYMENT
I acknowledge it is my responsibility to pay for any services I receive from the MSU HealthTeam.

_________________________________________ Date
Signature

IF I HAVE INSURANCE, I acknowledge Michigan State University HealthTeam will disclose protected health information to my insurance carrier or other third party responsible for my bill as required in order to receive reimbursement for services provided. This information may include mental health treatment, genetic testing, and information about serious communicable diseases, such as STDs, hepatitis, HIV and AIDS.

I authorize and request assignment of benefits to be paid directly to Michigan State University. I acknowledge and agree to pay any unpaid balances not covered by my insurance policy, including deductibles, co-payments, and unauthorized or out of network services.

_________________________________________ Date
Signature

MEDICARE PATIENTS ONLY
I authorize and request that payment of authorized Medicare benefits be made to the MSU HealthTeam on my behalf for any services furnished to me by a provider of the MSU HealthTeam.

_________________________________________ Date
Signature

MSU HEALTHTEAM NOTICE OF PRIVACY PRACTICE
I acknowledge that I have been offered the MSU HealthTeam Notice of Privacy Practices

_________________________________________ Date
Patient Name (please print) Signature

COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION
If you want us to speak with another individual about your care, please list their name, relationship to you, and phone number:

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<thead>
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<th>Name</th>
<th>Relationship</th>
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_________________________________________ Date
Signature
E-MAIL CONSENT FORM FOR NON-SECURE E-MAIL

Patient Name: _____________________________ Date of Birth: ______________

Patient E-mail Address: ________________________________________________

- MSU HealthTeam cannot guarantee the security and confidentiality of an e-mail transmission. Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.

- E-mail is best suited for routine matters and simple questions. You should not send us e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail but cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

- Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

- Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the “Subject” line of your message.

- All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health information.

- Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the HealthTeam without your authorization.

- In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

- You are responsible for protecting your password or other means of access to e-mail.

Signature of Patient: __________________________________ Date: ______________

Witness: _____________________________ Date: _____________________________
NOTICE OF PRIVACY PRACTICES

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Obtain Access to This Information. Please Review It Carefully.

The Michigan State University HealthTeam is a multi-specialty medical practice which is comprised of teaching faculty from MSU’s College of Human Medicine, College of Osteopathic Medicine, and the College of Nursing. All of the HealthTeam clinics located in the greater Lansing area share a common electronic health record (EHR).

We are required by law to maintain the privacy of your protected health information and to provide you with information that describes our privacy practices. This Notice of Privacy Practices describes how the MSU HealthTeam will use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are required or permitted by federal, state, and local law. This Notice also contains information about your rights to access and control your protected health information.

Uses and Disclosures of Protected Health Information for Treatment, Payment, or Health Care Operations

Federal privacy rules permit the MSU HealthTeam to use and disclose your protected health information without your written authorization for the purposes of treatment, payment, or health care operations.

TREATMENT: Your protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination and/or management of your health care with another health care provider for treatment purposes. The MSU HealthTeam participates in certain health information exchanges to facilitate the secure exchange of your health information electronically between health care providers and health care entities for your treatment, payment, or other healthcare operations purposes. This means that we may share information we obtain or create about you with outside entities (such as hospitals, doctor’s offices, and pharmacies) or we may receive information they create or obtain about you so that each of us can provide better treatment and coordinate your health care services.

Examples: The MSU HealthTeam may disclose protected health information to other health care providers, such as your primary care physician or when we refer you to a specialist who will participate in your treatment. We may disclose your protected health information to a pharmacy in order to fill your prescription, or to coordinate referrals for other health care services such as radiology or physical therapy.

PAYMENT: Your protected health information will be used and disclosed to obtain payment for the services we provide to you. This includes communicating with your insurance carrier about your insurance benefits.

Examples: The MSU HealthTeam will disclose protected health information to your insurance carrier in order to receive payment for our services. We may disclose protected health information in order to determine if you are eligible for specialized services, the range of services that can be provided, and to obtain prior approval, if needed, for those services.

HEALTH CARE OPERATIONS: Your protected health information will be used and disclosed in order to operate our practice. Health care operations include activities such as quality assessment and improvement; providing educational training programs for medical, nursing, and other allied health and non-health care professionals; accreditation, certification, and licensing activities; and general administrative, legal, and auditing activities.

Examples: The MSU HealthTeam may use protected health information in the training of health professions students who are working in our clinics. We may use protected health information to evaluate the quality of care that you receive from us, or to conduct cost-management and business planning activities. We may disclose protected health information to a business associate who performs a function or activity on our behalf, such as a typing services or collection services.

Certain Other Uses and Disclosures: Your protected health information may be used to remind you of appointments, medication refills, treatment alternatives, and/or other health-related benefits and services that may be of interest to you. We may disclose limited protected health information to a family member or close personal friend that you designate as being involved in your care.

Uses and Disclosures of Protected Health Information That Are Required or Permitted by Law

Public Health Activities: We will use and disclose your protected health information for the following public health activities and purposes as required or permitted by law:

- To prevent, control, or report disease, injury, or disability.
- To report suspected child abuse or neglect.
- To conduct public health surveillance, investigations, and interventions.
- To collect or report adverse events and product defects; enable product recalls, repairs, or replacements to FDA-regulated products or activities; and to track FDA-regulated products or conduct post-marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- To report to an employer about an individual who is a member of the workforce if there is a work-related injury or illness or to conduct an evaluation relating to medical surveillance of the workplace.
- To report proof of immunizations to a school about an individual who is a student or prospective student of the school.

To Report Suspected Abuse, Neglect, or Domestic Violence: We will use and disclose your protected health information to notify government authorities as required by law if we believe you are the victim of abuse, neglect, or domestic violence. If we make such a disclosure, we will inform you unless we believe that this will place you at risk of serious harm.

Health Oversight Activities: We will disclose your protected health information to a health oversight agency for activities authorized by law including audits; civil, administrative, or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight.
JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We will use and disclose your protected health information in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena to the extent authorized by law.

LAW ENFORCEMENT: We will disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting certain types of wounds or other physical injuries.
- Pursuant to a court order, court-ordered warrant, subpoena, summons, or similar process authorized under law.
- For the purposes of identifying or locating a suspect, fugitive, material witness, or missing person.
- Under certain circumstances when there is a crime on our premises.
- In an emergency, to report a crime.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: We may disclose your protected health information to a coroner or medical examiner for identification purposes, to determine cause of death, or to perform other duties authorized by law. We may disclose your protected health information to a funeral director in order for them to carry out their duties. We may disclose your protected health information if you are an organ donor for organ, eye, or tissue donation purposes.

RESEARCH: We may use and disclose your protected health information for research purposes when our institutional review board or privacy board waives the requirement to obtain an individual authorization.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: We may disclose your protected health information when necessary to prevent or lessen a serious and imminent threat to your health or safety, or the health and safety of the public.

SPECIALIZED GOVERNMENT FUNCTION: We may use and disclose your protected health information to facilitate specific government functions relating to military and veterans activities, national security and intelligence activities, protective services to the President and others, medical suitability determinations, public benefit programs, correctional institutions and law enforcement custodial situations.

WORKERS’ COMPENSATION: We may use and disclose your protected health information to comply with laws related to workers’ compensation or similar programs established by law to provide benefits for work-related illnesses or injuries.

OTHER AS REQUIRED BY LAW: We will use and disclose your protected health information to the extent that such use or disclosure is required by laws not listed above.

Other than as stated in the previous paragraphs, we will not disclose your PHI without your written authorization. We are specifically required to obtain your written authorization for all treatment and health care communications (except face to face) if the HealthTeam receives financial remuneration from a third party whose product or service is being marketed in exchange for making the communication. In addition, most uses and disclosures psychotherapy notes will only be made with your written authorization. You may revoke your written authorization at anytime, except to the extent that action has been taken in reliance on the authorization.

YOUR RIGHTS UNDER THE PRIVACY RULE:

- The right to inspect and request a copy of your protected health information, to the extent allowed by law. You may inspect and obtain a copy (paper or electronic) of the protected health information that is contained in your designated record set for as long as we maintain the protected health information. The designated record set contains both medical records and billing records. A fee may be charged to cover the copying, supplies, and postage costs incurred in complying with your request.
- The right to request communication of your protected health information by an alternative means or at an alternative location. You may request that we communicate with you in certain ways and we will accommodate reasonable requests. We will not require you to provide an explanation for your request.
- The right to request a restriction on the use and disclosure of your protected health information for treatment, payment, or health care operations purposes. With one exception, we are not required to agree to a restriction and will notify you if we deny the request. If we do agree, your protected health information will not be used or disclosed in violation of the restriction unless it is needed to provide you with emergency treatment. We are required to agree to the restriction if you pay 100% out of pocket for items or service and request that we do not disclose this to your health plan.
- The right to request amendments to your protected health information. This right must be in writing and you must provide a reason to support the requested amendment. In certain cases, we may deny your request. If we do, you have the right to file a statement of disagreement with us. If we prepare a rebuttal to your statement of disagreement, we will provide you with a copy.
- The right to receive an accounting of certain disclosures. You have the right to receive an accounting of certain disclosures of your protected health information by the MSU HealthTeam. Your request for an accounting must be in writing and you are permitted one free accounting during any 12-month period but subsequent requests for an accounting will incur a fee.
- The right to be notified of a breach of your protected health information. The HealthTeam must notify you as soon as possible and no later than 60 days following discovery of the breach.
- The right to obtain a paper copy of this Notice. You may ask for a copy of this Notice at any time. You may also access the Notice on our website at www.healthteam.msu.edu.

If you are interested in pursuing any of these rights, please discuss them with your health care provider or contact the MSU HealthTeam Privacy Officer at (517) 355-1822.

CHANGES TO THIS NOTICE:

We reserve the right to revise, change, or amend our Notice of Privacy Practices. Any revisions or amendments to this notice will be effective for all of the protected health information that we already have as well as any protected health information that we may create, receive, or maintain in the future. The MSU HealthTeam will post a copy of our current Notice in prominent locations within our clinics and you may request a current Notice during any visit to our organization or by calling the MSU HealthTeam Privacy Officer at (517) 355-1822. In addition, you will find our current Notice on our website at www.healthteam.msu.edu.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the Michigan State University Privacy Officer or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing. You will not be penalized for filing a complaint.

Effective Date: February 1, 2005

Revision Date: April 1, 2013