WHAT YOU CAN DO:

Talk to your program rights advisor. Maybe together you can find a simple solution to your complaint.

If that doesn't work, you can fill out a formal complaint. Your rights advisor has complaint forms.

After you give your complaint to your rights advisor, the complaint will be investigated. You will get a written answer to your complaint within 30 working days.

If you don't accept the written answer to your complaint, you have 15 working days to file an appeal to the regional rights consultant. Your rights advisor will provide you with appeal forms or you can send for one by writing to the address on the back of this brochure.

Within 30 working days, the regional rights consultant will give you a written answer to your appeal.

If you don't agree with the written answer to your appeal, you can file another appeal to the state rights coordinator.

YOUR PROGRAM RIGHTS ADVISOR

Name Chelsie Sheldon

Phone 586-250-4040

For additional information or to obtain forms to initiate a complaint, contact your local Substance Abuse Coordinating Agency at:

LARA
LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Revised 8/14

know your RIGHTS

YOUR RIGHTS

We are dedicated to providing you with quality services. We also believe that as someone who is receiving services from our program, you should know your rights. You should know how to make a complaint if you believe any of your rights have been violated.

YOU HAVE THE RIGHT TO KNOW:

- How much our services cost, and how much you must pay
- When violation of program rules could lead to your discharge
- All about any drugs that are used in your treatment
- If you, or information about you, will be used in any research or experiments.

YOU HAVE THE RIGHT TO:

- All civil rights guaranteed by state and federal law
- Suggest changes in our services
- Expect us to look into your complaints
- Help make up your own treatment plan
- Refuse our services and be told what will happen if you do
- Talk with your own doctor or lawyer
- Obtain a copy or summary of your client record unless the program director recommends otherwise

YOU HAVE THE RIGHT TO EXPECT THAT PROGRAM STAFF WILL NOT:

- Abuse and neglect you
- Give out information about you without your permission
- Require you to be part of any research if you don't want to

AND:

If you are in a hospital, halfway house, or other live-in setting, you have some additional rights.

All of these rights have some special limits. Check with your program rights advisor for further details. These additional rights include the right to:

- Know all the rules about having visitors
- Not be restrained – physically or by drugs, unless authorized by a physician
- Refuse to do work for us unless the work is part of your treatment plan
- Have space to put your personal belongings
- Keep your own money

If you want to know more about your rights, please read the recipient rights poster in the lobby or ask the program rights advisor for a more complete list of your rights.

YOUR RESPONSIBILITIES:

- You are responsible for payment of your bill
- You are responsible for knowing if your insurance company will pay for part or all of your bill
- You are responsible for providing clear and accurate information about yourself
- You are responsible for following rules of our program
- You are responsible for being considerate of the rights of others who are recipients of services or our staff

YOU AND YOUR RIGHTS ADVISOR

If you think your rights have been violated at our program, please talk to your rights advisor. This person is interested in listening to your complaint and helping you find a solution.

Your rights advisor's name and phone number are on the back of this brochure. Please contact your rights advisor if you believe your rights have been violated.

Gammons Medical Mission Statement

It is the mission of Gammons Medical to increase the level of civility in society. Civility is respect for humanity. When we are civil to one another we are happier. We feel better about ourselves and others feel better about themselves.

Absolute Purity refers to absolute purity of intent. Purity of intent means doing the right thing the right way and for the right reasons. Pure intentions mean approaching a situation, whatever that may be, without self-centeredness. Absolute Purity is civil.

Most of us are civil. We are only human so none of us are expected to be perfect, but we can try our best to be civil and act with purity of intent. It doesn't cost anything and it's not the least bit tricky.

Our mission at Gammons Medical is to provide superior medical care in an atmosphere of unusual civility.

Office Policies and Procedures

The following is a list of patient rules and expectations for remaining in compliance with Gammons Medical. If any patient/client fails to comply with the following, their treatment regimen and qualifications for continued service will be re-evaluated and increased, or subject to dismissal from the practice.

Insurance Responsibility

Please understand that running a medical practice is expensive and requires money. The insurance plan you chose to contract with may require payments for certain services. Gammons Medical assumes no liability for any benefit information that is misquoted by your insurance carrier. It is your responsibility to be aware of your insurance coverage, limitations, terms and conditions of your policy.

Your benefits and eligibility are verified prior to your appointment as a courtesy to you. Gammons Medical is not responsible for any information that is obtained directly from your insurance carrier that is later deemed inaccurate. You are responsible for payment of any deductible, co-payments, and co-insurances determined by your policy. This must be paid prior to your office visit unless prior arrangements have been made. Patients that are unprepared for payment will not be seen and will be rescheduled.

Patients are responsible for all copays and service fees. If you have an outstanding balance, you must be prepared to pay the remaining balance in addition to the day's service fees. This is non-negotiable unless arrangements have been made by management prior to the office visit.

No Show Policy

Failure to cancel an appointment within 24 hours prior to the scheduled appointment time will result in a No-Show fee being charged to the patient.

A No Show fee of $35 applied for counseling and $10 for office visits missed appointments.

No Show fees must be paid prior to your appointment or you will not be seen.

If you arrive late to your appointment (15 minutes or later) and still wish to be seen that day, you will be charged a $10 No Show fee and will have to wait for the next availability time slot. If none are available, you will be rescheduled to a different day or location.

Paperwork

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Gammons Medical will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow a minimum of3 business days for completion. Some forms may require an office visit with a provider to review details, including but not limited to FMLA forms to ensure proper completion.

Medication Refill Requests

We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days so please be courteous and do not wait to call. Refills can only be authorized on medication prescribed by Gammons Medical Providers only. We will not refill medications prescribed by other providers. MEDICATIONS FOR CONTROLLED SUBSTANCES WILL NOT BE REFILLED WITHOUT AN OFFICE VISIT.

Prior Authorization

Certain insurance companies require prior authorization for medications that are not on their formulary. This process can take 48-72 hours before we get a response from the insurance company. Please be patient during this time and contact your insurance company directly in order to expedite the process.

Treatment Contract

I hereby give permission for Gammons Medical to give me medical treatment. I allow Gammons Medical to file for insurance benefits to pay for the care I received.

I understand that:

- Gammons Medical will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Zero Tolerance Respect Policy

No member of our staff shall be subject to any abuse by any patient for any reason.

Gammons Medical is dedicated to providing a safe atmosphere for its employees and patients. Any argumentative, disrespectful, or otherwise violent behavior towards any staff or other patients WILL NOT BE TOLERATED and those who are in violation of this WILL BE DISCHARGED FROM THE PRACTICE IMMEDIATELY. Gammons Medical will not allow competent, compassionate staff to feel threatened by a patient who feels entitled to abuse them.

PATIENT REGISTRATION

Today's Date: _____ Allergies: _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

Address _____ City _____

State _____ Zip _____ Telephone # _____ (Home) _____ (Cell)

Email _____

Birth Date ____/____/____ Age _____ Sex _____ Marital Status: ( )Single ( )Married ( )Widow ( )Divorced

S.S. # _____ Drivers License # _____

Employer _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Person Financially Responsible for Payment (if not yourself) _____

Relationship _____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber _____

Subscribers Date of Birth ____/____/____ Relationship _____

S.S. # _____ Insurance Card # _____

Secondary Insurance _____ Subscriber _____

Subscribers Date of Birth ____/____/____ Relationship _____

Insurance Card # _____

Do you have any other insurance? ( ) Yes ( ) No

Insurance Co. _____ Subscriber _____

ADDITIONAL INFORMATION

WHOM TO NOTIFY IN CASE OF EMERGENCY:

Name _____ Telephone # _____

Relationship _____

How did you hear about us? _____

GAMMONS MEDICAL
HIPAA AUTHORIZATION FORM

Patient's Full Name _____ Patient's Social Security Number _____

Address _____ Patient's Date of Birth _____

City, State, Zip Code _____ Patient's Phone Number _____

I authorize use or disclosure of my protected health information about me as described below.

1. *The following specific person/facility is authorized to use or disclose information about me.*
2. *The following may receive disclosure of my protected health information.*

His/Her Name _____ Relationship _____ Phone Number _____

His/Her Name _____ Relationship _____ Phone Number _____

His/Her Name _____ Relationship _____ Phone Number _____

Can we send text messages, voice and email reminders of your appointment?

May we send SMS text and/or voice reminders? Yes _____ No _____ If yes, what phone number?_____

May we identify ourselves over the phone? Yes _____ No _____

May we leave messages? Yes _____ No _____

May we send emails? Yes _____ No _____ If yes, What email?_____

PLEASE NOTE THAT INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE; HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

Signature of Individual (The person about whom the information relates) _____ Date of Individual's Signature _____ Date of Birth or Social Security Number _____

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate _____ Date of Guardian's/Personal Representative's Signature _____ Description of Authority to Act for the Individual _____

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness, in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances
Pharmacy Name Phone	

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed By

_____ Date

Pre-Treatment Screening

Date: _____/_____/_____

Name: _____ DOB: _____/_____/_____

Substances Used:

Please circle response and fill in the blanks when appropriate.

Stimulants: Never used Currently using Past use Age first used_____
e.g. Adderall, cocaine, crack, methamphetamine, etc.

Benzodiazepines: Never used Currently using Past use Age first used_____
e.g. Xanax, Valium, Klonopin, Ativan, Librium, etc.

Opiates: Never used Currently using Past use Age first used_____
e.g. heroin, morphine, Tylenol #3, Percocet, Norco, etc.

Marijuana: Never used Currently using Past use Age first used_____

Alcohol: Never used Currently using Past use Age first used_____

If you circled "currently using" to any of the above, please specify below.

Substance: _____ Daily amount ($, # of tablets, grams, etc.): _____
Substance: _____ Daily amount ($, # of tablets, grams, etc.): _____
Substance: _____ Daily amount ($, # of tablets, grams, etc.): _____
Substance: _____ Daily amount ($, # of tablets, grams, etc.): _____
Substance: _____ Daily amount ($, # of tablets, grams, etc.): _____

Any legal problems due to substance use? _____

Any mental health disorders that are pre-existing or have been worsened by substance use: _____

_____

Have you attempted to cut down or stop alcohol or drug use on your own before? Yes No

Any history of previous treatment for alcohol or drug use? Describe (approximate dates, type, setting).

_____

Any current of past psycho-social support (e.g. individual therapy, group therapy, 12-step support (AA or NA meetings), peer recovery coach, etc.)? _____

Any other information you think is important for us to know? (Pregnancy) _____

_____

Gammons Medical Buprenorphine Treatment Agreement

Est. 2003

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment agreement as follows:

Buprenorphine is a medication approved by the Food and Drug Administration (FDA) for the treatment of people with opioid dependence. Buprenorphine can be used for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

I understand:

- There are alternatives to Buprenorphine/Naloxone treatment for opioid use disorder including:
  - Medical withdrawal and drug- free treatment
  - Naltrexone treatment
  - Methadone treatment
- The form of buprenorphine I will be taking is a combination of buprenorphine with naloxone.
- Buprenorphine/naloxone film or tab is to be placed under the tongue for it to dissolve and to be absorbed.
- Buprenorphine itself is an opioid, I know that taking buprenorphine regularly can lead to physical dependence and if I abruptly stop taking it, I could experience symptoms of opioid withdrawal.
- Mixing buprenorphine with traditional opioids and/or other substances of abuse may be extremely dangerous and even fatal.
  - Benzodiazepines (i.e. Xanax, Valium, Klonopin, Ativan, Librium, etc,.) are generally not appropriate for use with Buprenorphine/Naloxone. I understand that combining buprenorphine/naloxone with benzodiazepines has been associated with severe adverse events and even death.
  - I also understand that drinking alcohol while taking buprenorphine could produce medically adverse events such as over sedation, impaired thinking or other medically dangerous events.
- My provider(s) should be informed about a relapse before any drug test shows it.
- Medication WILL NOT BE CALLED IN to a pharmacy if it is lost, misplaced, or stolen. An office appointment and evaluation are required for additional prescriptions, along with a police report if stolen.
- I should not drive a motor vehicle or operate machinery if buprenorphine causes dizziness, drowsiness, or sedation. You should not drive or operate machinery until you know how buprenorphine/naloxone affects you.

FOR WOMEN ONLY: I agree to tell my provider if I become pregnant or even think I may be pregnant.

Gammons Medical Substance Abuse Treatment Agreement

Est. 2003

I agree to:

- Report my history and symptoms honestly to the healthcare provider involved in my care.
- Inform Gammons Medical of all other appointments with healthcare providers, including dentists; and any medications (prescription or non-prescription) that I am taking.
- Be open and honest with my healthcare providers and inform staff about cravings and potential relapse.
- Not arrive at the office intoxicated or under the influence of alcohol and/or other substances. If I do, the staff may choose not to see me and it may be determined to inform the appropriate services (i.e., police, EMS, etc.) due to safety concerns. My medication refill(s) will be withheld until such time that I am no longer under the influence.
- Not sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for an appeal.
- Keep and be prompt at all times to all my scheduled appointments with Gammons Medical providers and offices. I agree that my medication can only be given to me at my regular office visits. As a result of any missed office visit appointments, my medication will not be available until the next scheduled visit.
- Keep my medication in a safe, secure place environment and out of reach of children; as part of my responsibility.
- Not obtain medications from any other sources without notifying Gammons Medical.
- Take my medication as prescribed.
- Provide a drug screen upon request of Gammons Medical provider at any time based on state regulations:
    - If there is confirmed and validated evidence of a diverted urine, I agree to submit to a monitored urine sample and/or be required to return for a pill count. I understand that I may also be required to attend either group or individual counseling prior to receiving my next prescription. The determination of whether any client will be required to submit to these services will be handled on a case-by-case basis from the provider.
    - If a patient showed verified evidence of three (3) or more drug screens demonstrating diversion, they will be discharged from Gammons Medical.

I understand that violation of ANY OF THE ABOVE may be grounds for termination of treatment WITHOUT RECOURSE FOR AN APPEAL.

_____	_____	_____
PATIENT'S PRINTED NAME	SIGNATURE	DATE

MHP
Michigan Healthcare
PROFESSIONALS

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management/addiction treatment program. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

I understand that there is a risk of psychological and or physical dependence/addiction associated with chronic use of controlled substances.

I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship, and my provider undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my provider will stop prescribing these controlled medications.

In this case, my provider may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I would also be amenable to seek psychiatric treatment and/or psychological treatment if my provider deems necessary.

I will communicate fully with my provider about the nature and intensity of my pain/addiction, the effects of the pain/addiction on my daily life and how well the medicine is helping to relieve the pain/addiction.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate any legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

I will not share my medication with anyone.

I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

I will safeguard my pain medication from loss, theft or unintentional use by others including children. Lost or stolen medications will not be replaced.

I agree that refills of my prescriptions for pain/addiction medications will be made only at the time of an office visit in regular office hours. No refills will be available during evenings or on weekends.

You Must Have Urine Drug Screening as directed by your provider per state regulations.

MHP
Michigan Healthcare
PROFESSIONALS

I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit toa blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring unused pain medicine to every office visit.

I agree to follow these guidelines that have fully explained to me.

All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into this day _____

Patient Signature _____

Patient Printed Name _____

I have received a copy of the Office Policy and Procedures of Gammons Medical

By signing, I hereby state the below statements are true

_____

Lawsuit

Have you ever filed a lawsuit against a physician, hospital or any other healthcare entity?

____ Yes ____ No

If yes, please state how many times and provide a description of the case below:

_____
_____
_____
_____
_____
_____
_____

Guardian Contract

I _____ do not have a Legal Guardian at this time, Date _____/_____/_____.
I agree to inform Gammons Medical at the time someone has guardianship over me.

Signature: _____ Date: _____

I _____ do have a Legal Guardian. The Guardian is _____.

I agree that the Legal Guardian has to sign paperwork with Gammons Medical, giving permission to provide me with medical services. Gammons Medical will also need a copy of the Guardian Paperwork. At the time Legal Guardianship changes, I am responsible for informing Gammons Medical.

Signature of Patient: _____ Date: _____

Print Name of Guardian: _____

Signature of Guardian: _____ Date: _____

Zero Tolerance Respect Policy

Revisited

*Note --- the following policy may be found in your "Gammons Medical New Patient Paperwork".

No Member of our staff shall be subject to any abuse by any patient or guest for any reason.

Gammons Medical is dedicated to providing a safe atmosphere for its employees and patients. Any argumentative, disrespectful, or otherwise abusive behavior towards any staff or other patients/guests **WILL NOT BE TOLERATED** and those who are in violation of this **WILL BE DISCHARGED FROM THE PRACTICE IMMEDIATELY**. We will not allow competent, compassionate staff to feel threatened by any individual.

By signing this document, I agree to the following terms...

1. I have reviewed the document
2. I will comply with the above expectations
3. I understand this document serves as a warning
4. I understand this document will be entered into my Electronic Medical Record
5. I understand that violation from the above shall result in discharged from the practice

X _____ X _____ X _____

Print Name | Signature | Date

X _____ X _____ X _____

Provider Print Name | Provider Signature | Date

ELECTRONICS POLICY

Phone must be turned off or put away during the office visit with the provider.

Video and/or Audio Recording of any conversation within the Gammons Medical facility including office visit without the knowledge or authorization of people involve with the conversations is prohibited and against the office policy.

Violation of the above policies will result in immediate discharged from the practice.

Acknowledgement:

_____	_____
PRINT NAME	SIGNATURE
_____	_____
DOB	DATE

LARA

LICENSING AND REGULATORY AFFAIRS

CUSTOMER DRIVEN. BUSINESS MINDED

By signing this, I hereby state I have received a copy of Know Your Rights Brochure from Licensing and Regulatory Affairs.

Patient Signature: _____

Date: _____

gammons medical est. 2003
absolute purity

WWW.GAMMONSMEDICAL.COM

MEDICAL CONSENT FORM

I, _____, do hereby agree to give my consent to the providers of Gammons Medical to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical, mental or substance abuse condition. I understand my provider may utilize a medical assistant to assist with my plan of care.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Legal Guardian Name: _____ Date: _____

Legal Guardian Signature: _____

28477 Hoover Rd. • Warren, MI 48093 • Phone: 586-250-4040 • Fax: 586-486-5726
1223 S. Washington • Royal Oak, MI 48067 • Phone: 248-439-1060 • Fax: 248-439-1063
35640 West Michigan Ave. • Wayne, MI 48184 • Phone: 734-713-8866 • Fax: 734-589-6159
3803 Elizabeth Lake Rd. • Waterford, MI 48328 • Phone: 248-221-7733 • Fax: 248-221-7928
68560 Stoecker Ln. • Richmond, MI 48062 • Phone: 586-250-4040 • Fax: 586-900-6440
309 Ecorse Rd • Ypsilanti, MI 48198 • Phone: 734-484-0580 • Fax: 734-484-6410

gammons medical est. 2003
absolute purity

WWW.GAMMONSMEDICAL.COM

Telehealth Appointment Guidelines

- Telehealth appointments are a privilege not an expectation based on patient availability. In person office visits are the gold standard for optimal patient care.
- Telehealth appointments will be scheduled at providers discretion. Accommodations based on health status, transportation and/or working hours will be made at the providers judgement.
- At minimum, patients are expected to be seen for an in-office appointment at 3-month intervals for routine clinical evaluation.

Patient signature: _____

Printed name: _____

28477 Hoover Rd. • Warren, MI 48093 • Phone: 586-250-4040 • Fax: 586-486-5726
1223 S. Washington • Royal Oak, MI 48067 • Phone: 248-439-1060 • Fax: 248-439-1063
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