

Beals Institute
4333 W. St. Joe Hwy.
Lansing, Michigan 48917

**WELCOME TO
BEALS INSTITUTE**
Part of Great Lakes Center of
Rheumatology

The Beals Institute health care providers are committed to bringing you a quality of excellence in health care. Our areas of focus are arthritis, osteoporosis, musculoskeletal, autoimmune, and related diseases.

- Your visit and services will focus on evaluation of your current health problem and resolution for that problem.
- Review of labs, x-rays, and special studies that pertain to your specific problem.
- Evaluation of your current health care plan, to plan for future care and prevention of new health problems, and to guide the patient in becoming knowledgeable and self empowered to direct their own health care.

BEALS INSTITUTE
Part of Great Lakes Center of
Rheumatology

CAROL A. BEALS, MD
TIMOTHY PALMER, PA-C
KIMBERLY FRAZIER, NP
BRITTANY GEERDES, NP

Office hours by appointment only
Phone (517) 321-1525

Welcome to our office. Our goal is for you to receive state of the art health care. We would like to take this opportunity to explain our office policies.

- We are committed to assisting our patients in utilizing their health insurance plans but with greater than 100 plans in existence, you must be the one who is the expert on your plan.
- Beals Institute participates in select insurance carriers and HMO's. We recommend that you verify our participation in your plan. We will bill eligible services to your primary insurance carrier.

HMO/PPO PLANS: You must provide written authorization from your primary care physician for your visit. You will be held responsible for any unauthorized services.

- If you have an insurance other than those we participate with, we will complete claim forms for diagnostic test and procedures. It is the patient's responsibility to collect payment from their insurance carrier.

FEES FOR OUR SERVICES

- Fee schedules are available. Please ask. Fees are based on the complexity of the problem, complexity of the problem solving, the number of problems, and insurance criteria. Office visits provided by Nurse Practitioners are the same fees as the physician or per Medicare and insurance regulations.

- Appointments cancelled without a notice of 1 business day will be subject to a cancellation charge of \$100 for a new patient and \$25 or more for a return visit.

- After your second visit services when your condition is stable, your care may be provided by a Nurse Practitioner or Physician's Assistant. All care provided is in coordination with the physicians.

- Nurse Practitioners and Physician's Assistants are Master's Degree educated in advanced health care. They are specifically further trained in rheumatology by our staff physicians.

Your new patient appointment is scheduled for:

Date: _____

Time: _____ am/pm

With: _____

Please call (517) 321-1525 to confirm your visit at least 2 business days prior to your visit.

Please have all insurance cards, authorizations, and picture identification available at check in.

Bring any recent lab or x-rays and a list of your current medications.

Thank you for selecting the Beals Institute for your quality medical care in arthritis and related care.



BEALS INSTITUTE

Part of Great Lakes Center of Rheumatology

ARTHRITIS, OSTEOPOROSIS AND AUTOIMMUNE DISEASES

4333 W. St. Joe Hwy, Lansing, MI 48917 • (517) 321-1525 • Fax (517) 321-7059

Thank you for choosing the Beals Institute. We would like to take this opportunity to acquaint you with our practice and provide you with some useful information before your visit.

1. Your First Visit

- Plan to arrive about 15 minutes early to fill out any paperwork.
- First visits may last up to 1-2 hours so please bring a book and/or a snack.
- Please remember that emergencies do occur and may delay your appointment.

* Please refrain from wearing any scented lotions or perfumes to your appointments or you may be rescheduled.

2. What To Bring

- Please bring your driver's license, all insurance information (including the cards), recent labs and x-ray reports and a list of your current medications.
- Please bring the enclosed new patient information filled out. It will speed up the check-in process if this information is complete.
- If your insurance requires an authorization, it is YOUR responsibility to contact your primary care physician and complete. Please check with your insurance to verify coverage, deductibles, and co-pays. Our staff will be happy to answer any questions regarding our physicians participation in the various insurance plans.
- **ALL CO-PAYS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA AND MASTERCARD.**

**** I understand that this office does not participate in Worker's compensation, No Fault Insurance, or any Auto Injury related cases and I will be responsible for payment if this visit is a result of such.**

I acknowledge that I have had the opportunity to receive a copy of this office's Notice of Privacy Practices.

Printed Name of Patient or Guardian

Date

Signature of patient or guardian

Date of Birth

There are continuously medical students, interns, resident, and fellows present in our clinic. These are doctors in training and work in the clinic under our supervision. We request your willingness to allow their participation in your care, and we assure you that they are closely monitored by us, and are capable of participating. It has been our experience that the teaching atmosphere improves the environment in our clinic, and actually improves the overall benefit to our patients.

We hope your visit with us is a pleasant one. If there is anything we can do to make your first visit more smooth, please do not hesitate to call us at 517-321-1525.

Thank you,

Beals Institute Scheduling Staff

Patient History Form

Date of First appointment: ____/____/____

Time of appointment: _____ am / pm

Name: _____ Birth Date ____/____/____
Last First MI Maiden Month Day Year

Address: _____ Age: _____ Sex: F M
Street Apt #

City State Zip Telephone: Home () _____
 Work () _____
 Cell () _____

Employer: _____

Marital Status: Never Married Married Divorced Widowed Partner

Name of spouse/partner: _____ DOB: _____

Spouse/Partner employed by: _____

If minor, Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Patient Education (Circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of Hours worked/average per week _____

Have you missed time at work due to illness and/or pain in the last year? No Yes If so, How much? _____

Name of referring Doctor: _____

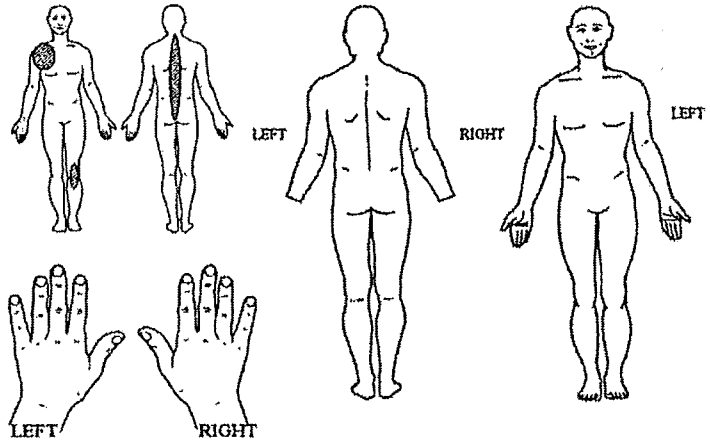
Name of Primary Care Doctor: _____

Briefly describe your present symptoms: _____

Approximate Date symptoms began:

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

*At any time have you or a blood relative had any of the following? (Check if "YES")

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment - Listening to the patient - A practical guide to self report questionnaires in clinical care. Arthritis Rheum 1999;42 (9):1797-808. Used by permission.

| Yourself | Relative Name/Relationship | Yourself | Relative Name/Relations |
|--------------------------|----------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | Arthritis (Unknown type) | <input type="checkbox"/> | Lupus or "SLE" |
| <input type="checkbox"/> | Osteoarthritis | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | Gout | <input type="checkbox"/> | Ankylosing Spondylitis |
| <input type="checkbox"/> | Childhood arthritis | <input type="checkbox"/> | Osteoporosis |

Other arthritis conditions: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Beals Institute to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to Beals Institute for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me on the pages below is current and correct. I request that payment of authorized benefits be made on my behalf. I have reviewed and agree with the Beals Institute privacy practices and financial policies.

Patient Name _____ DOB _____ Date _____

RACE

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ White

_____ Native Hawaiian

_____ More than one race

_____ Decline to report

ETHNICITY

_____ Hispanic or Latino

_____ Spanish

_____ Not Hispanic or Latino

_____ English

_____ Decline to report

_____ Other _____

PREFERRED LANGUAGE

Local Pharmacy _____

Mail-In Pharmacy _____

E-Mail Address _____

Patient Name _____ DOB _____ Date _____

SOCIAL HISTORY

Do you drink caffeinated beverages? Yes No
 If yes, what type? _____
 How many servings per day? _____
 Do you smoke currently? Yes No
 If yes, How many packs/day? _____
 How long? _____
 If quit, how many packs were you smoking? _____
 When did you quit smoking? _____
 Do you drink alcohol? Yes No
 If yes, how many drinks per day? _____, per week? _____
 Do you use drugs for purposes other than for medical reasons? Yes No
 If yes, please list: _____

 Do you have a medical marijuana card? Yes No
 Do you have a home exercise program that you do on a regular basis? Yes No
 If yes, what is it? _____
 How often do you exercise? _____

PREGNANCY HISTORY

Do you have children? Yes No
 If so, what year(s) were they born? _____
 # of times pregnant: _____ # of deliveries: _____ Miscarriages/abortions: _____
 # of living children: _____ # of deceased children: _____
 Are you currently pregnant? Yes No
 Birth control Method: _____

FAMILY HISTORY (Please mark appropriate numbers for family members)

- (1) High Blood Pressure (2) Heart disease (3) Epilepsy/seizures (4) Diabetes (5) Cancer (6) Asthma
- (7) Hay fever/allergies (8) Arthritis (9) Kidney disease (10) Glaucoma (11) Stroke (12) Migraine
- (13) Mental illness (14) Alcoholism (15) Bleeds easily (16) Anemia (17) Psoriasis (18) Eczema
- (19) Osteoporosis (20) Obesity (21) Blindness (22) Deaf (23) Mental Retardation

| Family Member | Alive | Deceased | #'s that apply | Cause of death/age |
|----------------|-------|----------|----------------|--------------------|
| Father | | | | |
| Mother | | | | |
| Brother/Sister | | | | |
| Brother/Sister | | | | |
| Brother/Sister | | | | |
| Brother/Sister | | | | |
| Mother's Mom | | | | |
| Mother's Dad | | | | |
| Father's Mom | | | | |
| Father's Dad | | | | |

IMMUNIZATIONS (Please write year of last injection)

_____ Pneumonia _____ Flu (Influenza) _____ Tetanus _____ Shingles _____ Mumps
 _____ Diphtheria _____ Measles _____ Rubella _____ Hepatitis _____ Other

Patient Name _____ DOB _____ Date _____

Drug Allergies: _____

Food/Environmental Allergies: _____

Current Medications (list **ALL** medications that you are currently taking, including vitamins, supplements and over-the-counter medications etc)

| Name of Medication | Dosage/mg | Frequency/How often medication is taken |
|--------------------|-----------|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |

Past Medical History- Do you now or have you ever had: (circle if "yes")

- | | | | | |
|---|----------------|---------------------|------------------|-------------------------|
| Cancer | Heart problems | GERD | Asthma | Goiter |
| Leukemia | Stroke | Cataracts | Diabetes | Epilepsy |
| Nervous Breakdown | Stomach Ulcers | Rheumatic Fevers | Headaches | Jaundice |
| Colitis | Kidney Disease | Pneumonia | Psoriasis | Anemia |
| HIV/AIDS | Emphysema | High Blood Pressure | Glaucoma | Tuberculosis |
| Weakness in arms/legs | Seizures | Night sweats | Loss of appetite | Change of taste in food |
| Difficulty controlling bowel/bladder function | Shingles | | | |

Other significant illnesses (please list) _____

Past Medications: Please review this list of medications. Please (✓) **YES** or **NO** to whether you have ever taken each medication in the past and whether it was helpful or not. If discontinued, please write the reason why. Please only mark the medications you have tried but are **NOT CURRENTLY TAKING**.

| MEDICATION | Taken | | Tolerated | | Helpful | | REASON DISCONTINUED |
|---|-------|----|-----------|----|---------|----|---------------------|
| | YES | NO | YES | NO | YES | NO | |
| NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs) | | | | | | | |
| Naproxen (Aleve) | | | | | | | |
| Ibuprofen (Motrin/Advil) | | | | | | | |
| Ketoprofen | | | | | | | |
| Oxaproxin (Daypro) | | | | | | | |
| Diclofenac (Voltaren) | | | | | | | |
| Indomethacin (Indocin) | | | | | | | |
| Ketorolac (Toradol) | | | | | | | |
| Etodolac (Lodine) | | | | | | | |
| Sulindac (Clinoril) | | | | | | | |
| Meloxicam (Mobic) | | | | | | | |
| Celebrex (Celecoxib) | | | | | | | |
| Salsalate (Disalcid) | | | | | | | |
| Nabumetone (Relafen) | | | | | | | |
| Other: | | | | | | | |
| PAIN RELIEVERS | | | | | | | |
| Acetaminophen (Hydrocodone/Tylenol) | | | | | | | |
| Codeine (Vicodin/ Tylenol #3) | | | | | | | |
| Darvocet/Darvon | | | | | | | |
| Tramadol (Ultram/Ultracet) | | | | | | | |
| Other: | | | | | | | |
| DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDs) | | | | | | | |
| Plaquenil (Hydroxychloroquine) | | | | | | | |
| Methotrexate | | | | | | | |
| Arava (Leflunomide) | | | | | | | |
| Imuran (Azathioprine) | | | | | | | |
| Sulfasalazine (Azulfadine) | | | | | | | |
| Quinacrine (Atabrine) | | | | | | | |
| Cyclophosphamide (Cytoxan) | | | | | | | |
| Enbrel | | | | | | | |
| Humira | | | | | | | |
| Remicade | | | | | | | |
| Other: | | | | | | | |
| GOUT MEDICATIONS | | | | | | | |
| Allopurinol (Zyloprim) | | | | | | | |
| Colchicine (Colcrys) | | | | | | | |
| Probenecid (Benemid) | | | | | | | |
| | | | | | | | |

Patient Name _____ DOB _____ Date _____

| MEDICATION | Taken | | Tolerated | | Helpful | | REASON DISCONTINUED |
|--|-------|----|-----------|----|---------|----|---------------------|
| | YES | NO | YES | NO | YES | NO | |
| OSTEOPOROSIS MEDICATIONS | | | | | | | |
| Estrogen (Premarin, etc) | | | | | | | |
| Alendronate (Fosamax) | | | | | | | |
| Evista (Raloxifene) | | | | | | | |
| Actonel | | | | | | | |
| Prolia | | | | | | | |
| Forteo | | | | | | | |
| Reclast | | | | | | | |
| ANTI-CONVULSANTS | | | | | | | |
| Gabapentin (Neurontin) | | | | | | | |
| Lyrica (Pregabalin) | | | | | | | |
| Topamax (Topiramate) | | | | | | | |
| Lamictal (Lamotrigene) | | | | | | | |
| MUSCLE RELAXERS | | | | | | | |
| Methocarbamol (Robaxin) | | | | | | | |
| Orphenadrine (Norflex) | | | | | | | |
| Tizanidine (Zanaflex) | | | | | | | |
| Metaxalone (Skelaxin) | | | | | | | |
| Baclofen (Lioresal) | | | | | | | |
| Cyclobenzaprine (Flexeril) | | | | | | | |
| Carisoprodol (Soma) | | | | | | | |
| ANTI-DEPRESSANTS | | | | | | | |
| Amitriptyline (Elavil) | | | | | | | |
| Nortriptyline (Pamelor) | | | | | | | |
| Fluoxetine (Prozac) | | | | | | | |
| Paroxetine (Paxil) | | | | | | | |
| Venlafaxine (Effexor) | | | | | | | |
| Duloxetine (Cymbalta) | | | | | | | |
| Milnacipran (Savella) | | | | | | | |
| Buspirone (Buspar) | | | | | | | |
| Velazodone (Viibryd) | | | | | | | |
| Bupropion (Wellbutrin) | | | | | | | |
| Escitalopram (Lexapro) | | | | | | | |
| Citalopram (Celexa) | | | | | | | |
| OTHERS | | | | | | | |
| Cortisone (Prednisone) | | | | | | | |
| Hyalgan, Euflexxa, Synvisc, Supartz, etc | | | | | | | |
| Herbal or Nutritional Supplements | | | | | | | |
| | | | | | | | |
| | | | | | | | |

DIAGNOSTIC TESTS

Which of the following diagnostic tests have been done? Please indicate date for "yes" answers. Please state if you have been unable to complete any of these tests, or if you have had a severe reaction to any of them:

| | Approximate Date | Reason testing not complete |
|--|-------------------------|------------------------------------|
| Spine X-Rays (L, C, T-spine) | _____ | _____ |
| CT Scan | _____ | _____ |
| Myelogram | _____ | _____ |
| MRI Scan | _____ | _____ |
| Bone Scan | _____ | _____ |
| EMG | _____ | _____ |
| Nerve Block | _____ | _____ |

PREVIOUS INJURIES, OPERATIONS OR HOSPITAL ADMISSIONS

| | <u>Type</u> | <u>Date/Year</u> | <u>Where/location</u> | <u>Reason</u> |
|-----|-------------|------------------|-----------------------|---------------|
| 1) | _____ | _____ | _____ | _____ |
| 2) | _____ | _____ | _____ | _____ |
| 3) | _____ | _____ | _____ | _____ |
| 4) | _____ | _____ | _____ | _____ |
| 5) | _____ | _____ | _____ | _____ |
| 6) | _____ | _____ | _____ | _____ |
| 7) | _____ | _____ | _____ | _____ |
| 8) | _____ | _____ | _____ | _____ |
| 9) | _____ | _____ | _____ | _____ |
| 10) | _____ | _____ | _____ | _____ |
| 11) | _____ | _____ | _____ | _____ |
| 12) | _____ | _____ | _____ | _____ |
| 13) | _____ | _____ | _____ | _____ |
| 14) | _____ | _____ | _____ | _____ |
| 15) | _____ | _____ | _____ | _____ |

***Please list the physicians and/or chiropractors you have seen for your pain, along with the approximate dates.**

| Type of doctor | Doctor's Name | Location | Approximate Date |
|-----------------------|----------------------|-----------------|-------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last Bone Density Test ____/____/____

Constitutional

- Recent weight gain
Amount _____
- Recent weight loss
Amount _____
- Fatigue
- Weakness
- Fever

Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

Ears, Nose, Mouth, Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Teeth grinding
- Sores in mouth
- Loss of taste
- Dryness in mouth
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmur

Respiratory

- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- Cough
- Coughing up blood
- Wheezing (asthma)

Gastrointestinal

- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by milk or food
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from vagina/penis
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

For Women only:

- Age when periods began: _____
- Periods regular? Yes No
- How many days apart? _____
- Date of last period? ____/____/____
- Date of last pap? ____/____/____
- Bleeding after menopause? Yes No
- Difficulty getting pregnant? Yes No

Musculoskeletal

- Morning stiffness
Lasting how long?
_____ mins _____ hrs
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
- List joints affected in the last 6 months:

Integumentary (skin and/or breast)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitivity (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Increased irritability
- Difficulty falling asleep
- Difficulty saying asleep

Endocrine

- Excessive thirst
- Loss of muscle strength/mass
- Muscle cramps
- Dry/coarse skin
- Intolerance to cold
- Intolerance to heat

Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/when _____

Allergic/immunologic

- Frequent sneezing
- Increased susceptibility to infection

PRIOR TREATMENT

Have you been satisfied with previous medical care? Yes No

If no, comment (optional): _____

A: Put a check next to each type of treatment you have had for your back/neck or pain problem in the past.

B: Check the column that best describes the effect of the treatment. If you have had treatments not given on the list, write them in at the bottom and indicate how they affected you.

| | Helped | Made things worse | Didn't do much either way |
|-------------------------------------|--------|-------------------|---------------------------|
| Stretching Exercises..... | _____ | _____ | _____ |
| Hot packs | _____ | _____ | _____ |
| Ultrasound..... | _____ | _____ | _____ |
| Ice | _____ | _____ | _____ |
| Massage | _____ | _____ | _____ |
| Electrical stimulation..... | _____ | _____ | _____ |
| TENS unit for home use..... | _____ | _____ | _____ |
| Body mechanics training | _____ | _____ | _____ |
| Physical Therapy | _____ | _____ | _____ |
| Strengthening exercises | _____ | _____ | _____ |
| Aerobics (e.g. exercise bike) | _____ | _____ | _____ |
| Gravity Inversion..... | _____ | _____ | _____ |
| Traction | _____ | _____ | _____ |
| Bed rest | _____ | _____ | _____ |
| Chiropractic treatment | _____ | _____ | _____ |
| Osteopathic Manipulation | _____ | _____ | _____ |
| Biofeedback | _____ | _____ | _____ |
| Trigger point injections | _____ | _____ | _____ |
| Epidural (spinal) injections..... | _____ | _____ | _____ |
| Facet joint injections | _____ | _____ | _____ |
| Soft back brace | _____ | _____ | _____ |
| Rigid back brace | _____ | _____ | _____ |
| Acupuncture | _____ | _____ | _____ |
| Anti-inflammatory medication | _____ | _____ | _____ |
| Narcotic pain medication | _____ | _____ | _____ |
| Muscle relaxant medication | _____ | _____ | _____ |
| Anti-depressant medication | _____ | _____ | _____ |
| Surgery | _____ | _____ | _____ |

Other: _____

Thank you very much for taking the time to fill out this form in its entirety. We understand that it is a very long and detailed form. It does however allow us to better serve your needs.



BEALS INSTITUTE

ARTHRITIS, OSTEOPOROSIS and AUTOIMMUNE DISEASES

Diplomat, American Board of Internal Medicine and Rheumatology, Board Certified

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Patient Name (print): _____ Date of Birth ____/____/____

I authorize Beals Institute to discuss medical and/or billing information, and/or provide my personal health information to the following individuals;

| | | | |
|-------|--------------------------|--------|--|
| Name | Relationship to Patient: | Phone: | <input type="checkbox"/> Medical <input type="checkbox"/> Appointment <input type="checkbox"/> Billing/Account |
| _____ | _____ | _____ | |

| | | | |
|-------|--------------------------|--------|--|
| Name | Relationship to Patient: | Phone: | <input type="checkbox"/> Medical <input type="checkbox"/> Appointment <input type="checkbox"/> Billing/Account |
| _____ | _____ | _____ | |

| | | | |
|-------|--------------------------|--------|--|
| Name | Relationship to Patient: | Phone: | <input type="checkbox"/> Medical <input type="checkbox"/> Appointment <input type="checkbox"/> Billing/Account |
| _____ | _____ | _____ | |

My preferred contact is: Phone OR FMH Patient Portal

The office:

MAY leave messages about my care on a voicemail at this number: _____

MAY NOT leave messages about my care on a voicemail or answering machine.

Expirations or termination of authorization – This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to the Beals Institute.

Redisclosure – We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Beals Institute.

Patient Signature

Date