BRONSON
LakeView Family Care

Date: _____

Dear_____

Welcome to Bronson LakeView Family Care – Mattawan. Thank you for choosing us for your Healthcare needs. Enclosed is our brochure outlining our guidelines. Also, there is paperwork for you to complete and bring with you to your appointment.

Health History Form

Please fill out the enclosed Health History form and bring it to your first appointment on _____. It is important _____ have a complete record of your medical history to make informed decisions about your care and treatment options. If this is not complete when you arrive for your first visit, you may need to reschedule your appointment.

Consent for release of information

You will also need to complete the enclosed authorization for release of information. You will need to mail it to your previous doctor as soon as possible. This will allow us to obtain your medical records for _____ to have available for your first visit.

Appointment Billing

_____ feels it is important for your health to complete a physical exam. Please be aware that many insurance companies do not cover routine or preventative services. This visit may be billed as a routine service and submitted to you insurance company as a routine service.

It is strongly recommended that you contact your insurance company prior to receiving these services to verify your insurance coverage. Please be aware if your insurance company does not pay for these services, you will be responsible for payment.

It is very important you bring your insurance card(s) to each visit so that we may submit a bill to your insurance company for you. Please be prepared to pay any copays or deductibles.

Additional Forms

- Registration Forms
- Financial Policy
- Bronson LakeView Medical Practices Authorization to Treat (If applicable)
- Parental Minor Consent form (if applicable)
- Advance Directive
- HIPPA – Notice of Privacy Practices
- Diagnostic Use of Authorization Form

Bronson LakeView
Family Care Decatur
319 W. Delaware St.
Decatur, MI 49045
269.423.7028
fax 269.423.8282

Bronson LakeView
Family Care Mattawan
52375 N. Main St.
Mattawan, MI 49071
269.668.3348
fax 269.668.7702

Bronson LakeView
Family Care Paw Paw
451 Health Parkway
Paw Paw, MI 49079
Ste. A 269.657.2550
fax 269.657.2285
Ste. B 269.655.3065
fax 269.655-0588

Bronson LakeView
Family Care –
Internal Medicine
451 Health Parkway
Paw Paw, MI 49079
269.655.3080
fax 269.655.0761

Bronson LakeView
Family Care – Pediatrics
451 Health Parkway
Paw Paw, MI 49079
269.655.3090
fax 269.655.0763

bronsonhealth.com/lakeview

BRONSON
LakeView Family Care

Testing

If you have an early morning appointment, you may wish to fast for 12 hours (nothing to eat or drink except water) before your appointment. This way, if _____ would like you to have fasting lab work done, you may do that while you are here and save yourself an extra trip. If you are not fasting or have a later morning or afternoon appointment, you can return to the lab for your blood work at another time.

An EKG may be performed during your visit, Please do not use any body lotions or creams on the day of your appointment.

Emergency & After Hours Calls

A Provider is on-call at all times to help with emergencies. If you feel your emergency is a matter of life or death, call 911 or go to the nearest emergency room. If you have an urgent need after hours, please call our office and you will be directed to a triage nurse. The nurse may provide advice, schedule an appointment or direct you to seek emergency care.

Bronson MyChart

Bronson MyChart is a free and secure way to look at parts of your medical record on your computer. You can review prescriptions, send messages to your Doctor or a member of our staff and schedule routine appointments. Ask our staff to set up your MyChart account.

Arrival Time

If you are unable to make your new appointment, Please contact us at least 24 hours in advance. If you fail to inform us that you cannot keep your new patient appointment, then the providers at Bronson LakeView Family Care – Mattawan may not see you as a patient.

Please arrive 15 minutes before your scheduled appointment time to complete the registration process. Patients arriving late may need to reschedule.

If you have any questions, please feel free to contact our office at 269-668-3348. We look forward to seeing you at you appointment.

Sincerely,

Bronson LakeView Family Care – Mattawan

Bronson LakeView
Family Care Decatur
319 W. Delaware St.
Decatur, MI 49045
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451 Health Parkway
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fax 269.655.0763

bronsonhealth.com/lakeview

BRONSON
LakeView

Request for Access or Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____
Last First MI

Date of Birth: _____
Month Day Year

I give permission to Bronson Medical Practices to use or disclose my protected health information indicated below to

Physician to release records:

Name_____

Address:_____

_____

Phone _____

Fax _____

Physician/Person to receive records:

Bronson Lakeview Family Care-Mattawan

52375 N. Main St.

Mattawan, MI 49071

Phone: (269) 668-3348

Fax: (269) 668-7702

Information to be released:
(Please check boxes that apply)

- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ Medication Records
- ☐ Detailed Bill

Other (specify content and dates) _____

Purpose of Disclosure:

- ☐ Changing doctors
- ☐ Consultation
- ☐ Insurance or Workers' Compensation
- ☐ School
- ☐ Research
- ☐ At request of individual
- ☐ Legal (specify) _____
- ☐ Other (specify) _____
- ☐ For my own use

I authorize the release of health information, contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statue and Michigan Department of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency Virus (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Acknowledgement of Understanding:

- I understand this authorization will expire in one year from date signed.
- I can cancel this authorization at any time by writing to Bronson Medical Group.
- It will take effect on the date notified, except if action has already been taken.
- I understand that if I release my medical record to a person or provider, they can release my medical record. I know I need to check with them about their privacy rules.
- I will get an abstract of my medical record unless I ask for the complete record.
- No conditions will be placed on me if I sign this form.

Michigan law says I may have to pay for:

- Copies of my record
- Inspection of my record
- Written summary of findings

Bronson Medical Practices will not benefit from disclosing this information.

_____ _____

Signature of Patient Date

_____ _____

Parent or Personal Representative Date

BRONSON
LakeView Family Care

☐ 319 W Delaware, Decatur, MI 49045 • (269) 423-7028
☐ 52375 N Main St, Mattawan, MI 49071 • (269) 668-3348
☐ 451 Health Parkway, Suite A, Paw Paw, MI 49079 • (269) 657-2550
☐ Surgery - 404 Hazen, Suite 101, Paw Paw, MI 49079 • (269) 657-4407
☐ 451 Health Parkway, Suite B, Paw Paw, MI 49079 • (269) 655-3065

Patient Name _____ Date of Birth _____ Date _____

NEW PATIENT HEALTH HISTORY FORM (PEDIATRIC)

Parent' or guardians' names _____

Race/Ethnicity: ___ Hispanic/Latino ___ White ___ Black/African American ___ Asian
___ Native Hawaiian/Other Pacific Islander ___ Other

Preferred Language _____

Mother's age _____ Occupation _____ Health _____

Father's age _____ Occupation _____ Health _____

Stepfather/mother living in home – Age _____ Occupation _____

Number of people living in home _____ # Smokers _____ Animals _____

Birth weight _____ Pregnancy complications _____

Born _____ weeks early/late Vaginal/C-section delivery _____

Delivery problems _____ Forceps _____

Name of delivering physician/hospital _____

Special nursery care/diet _____

List all hospitalizations/surgeries/traumas _____

_____

_____

_____

_____

Allergies _____

Medications _____

CHILD'S MEDICAL HISTORY

Vision Problems	Y	N	Hayfever/Sinus	Y	N
Eye Problems	Y	N	Frequent Headaches	Y	N
Frequent Ear Infections	Y	N	History of Head Injury	Y	N
Hearing Problems	Y	N	Seizures	Y	N
Frequent Sore Throats	Y	N	Attention Deficit Disorder	Y	N
Frequent Bronchitis	Y	N	Behavior Problems	Y	N
Pneumonia	Y	N	Mental Disability	Y	N
Asthma	Y	N	History of abuse	Y	N
Shortness of Breath	Y	N	Anemia	Y	N
Heart Problems	Y	N	Chest Pain	Y	N
Diarrhea	Y	N	Heart Murmur	Y	N
Constipation	Y	N	Fainting	Y	N
Frequent Stomach Aches	Y	N	Broken Bones	Y	N
Hernias	Y	N	Physical Disability	Y	N
Urinary Problems	Y	N	Bedwetting	Y	N

Patient Name _____ Date of Birth _____ Date _____

CHILDHOOD DISEASES (please mark if your child has had any of the following):

Chicken pox _____ Meningitis _____ Hepatitis _____ Polio _____ TB _____

Other significant problems/disease not mentioned _____

_____

_____

_____

FAMILY HISTORY

If any blood relative, going back to grandparents, has suffered from any of the following problems, please mark problem and which relative:

_____ Heart disease _____
_____ Stroke _____
_____ Cancer _____
_____ Diabetes _____
_____ High blood pressure _____
_____ High cholesterol _____
_____ Kidney disease _____
_____ Liver disease _____
_____ Lung disease _____

_____ Arthritis _____
_____ Glaucoma _____
_____ Epilepsy _____
_____ Allergies _____
_____ Mental illness _____
_____ Asthma _____
_____ Thyroid problems _____
_____ Alcohol/Drug Abuse _____

Any other problem or disease not mentioned that a family member has had that could affect your child _____

_____

_____

_____

List offices/physician names if known where child has been seen

_____

_____

_____

This is my important medical history. The doctor will use this information to make medical decisions about me. I am responsible to tell my doctor about my medical history on this form.

Signature _____ Date _____
(Parent/Guardian)

Provider Signature _____ Date _____

BRONSON

Affix Patient Label

Patient Demographics

Demographics – Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

SSN: _____/_____/_____ Sex: M / F / U Birth Date: ___/___/___

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip: _____ E-Mail Address: _____

Other Communication

Allowed Communication: ____ Do Not Contact ____ Mail ____ Phone _____Text
____E-mail ____ MyChart Signup

Needs Interpreter? Y/ N Language: _____

Marital Status: _____ Religion: _____

Ethnicity: Hispanic/ Not Hispanic

Race: _____

PCP Care Provider Information

Primary Care Physician: _____

Emergency Contact – In Case of Emergency, who to contact

Last Name: _____ First Name: _____ Middle Name: _____

Relation to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Employment

Employer: _____ Employment Status: _____ Not Employed

Affix Patient Label

Patient Name:_____ DOB:_____

Employer Address: _____ Employment date: _____

City: _____ Employee ID: _____

State: _____ Zip: _____ Occupation:_____

Phone: _____ Fax: _____

Religious Affiliation

Church: _____

Guarantor Accounts – If patient is over 18 years of age, see patient information

Last Name: _____ First Name: _____ Middle Name:_____

Account Type: Patient/Family / Workers Comp / Auto SSN: _____/_____/_____

Sex: M/F/U Birth Date: ____/____/____ Relation to Patient: _____

Address: _____ City: _____

_____ State: _____ Zip: _____

Home Phone: _____

Guarantor Employer: _____ Employ. Status: Full Time / Part Time

Address: _____ City: _____

_____ State: _____ Zip: _____

Phone: _____

Primary Coverage

Name of Coverage: _____

Member Relationship to Subscriber: _____

Affix Patient Label

Patient Name:_____ DOB:_____

Insurance ID: _____ Member Effective Date: _____

Group Number: _____ Group Name: _____

Authorization Phone: _____

Covered Through: Employment / Retirement Employer size: _____

Subscriber Name: _____ SSN: _____/_____/_____ Sex: M/ F / U

Birth Date: ___/___/___

Subscribers Address_____ City: _____

_____ State: _____ Zip: _____

Subscriber Phone: _____

Secondary Coverage

Name of Coverage: _____

Member Relationship to Subscriber: _____

Insurance ID: _____ Member Effective Date: _____

Group Number: _____ Group Name: _____

Authorization Phone: _____

Covered Through: Employment / Retirement Employer size: _____

Subscriber Name: _____ SSN: _____/_____/_____ Sex: M/ F / U

Birth Date: ___/___/___

Subscribers Address_____ City: _____

_____ State: _____ Zip: _____

Subscriber Phone: _____

Affix Patient Label

Patient Name:_____ DOB:_____

Visit Specific Information

Reason for Visit: _____

Accident Related: Y / N If Yes, Fill out Accident Information below

Accident Date: _____ Accident Time: _____

Accident Type: _____ Place of Injury: Home / Work / Other

Body Part Injured: _____ Accident Description: _____

_____

Referring Physician (if applicable):_____

MRN_____

CSN_____

BRONSON

Affix Patient Label

Patient Name:_____ DOB:_____

I. 01 Bronson Physician Practices Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates with a variety of insurance plans. If you are a member of one of these plans, our business office will submit a claim for services. If you have insurance for which we are not a contracted provider, we will bill the insurance as a courtesy. You must assign benefits to the practice so that payment will come directly to the practice. It is your responsibility to:
    - Provide us with current insurance and billing information including your Social Security Number, and bring your insurance card to each visit.
    - Be prepared to pay your co-pay at each visit.
    - Pay any balance not covered by your insurance plan including co-pays and deductibles.

- Patients with outstanding balances will receive monthly statements. The statements will indicate what, if any, of the outstanding balance is patient responsibility and what is pending insurance payment. Payment of outstanding patient balances is expected within 30 days of receipt of statement. Patient balances over 90 days will be sent to a collection agency.

- You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending a text message or e-mail, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

- **Payment for professional services can be made with cash, check or credit card. You may be billed separately for lab, x-ray, pathology and other hospital services. A charge of $25.00 will be assessed for all returned checks and patients will be expected to pay this charge by credit card, money order or in cash upon receipt of a statement.**

- Specialist Authorizations: It is your responsibility to ensure that any **required authorizations** for treatment are provided to the practice **prior to the visit.** If you do not have the authorization, your visit may be rescheduled, or you may be financially responsible.

- Primary Care Authorizations: If your primary care physician is not a Bronson Medical Group physician, **you are responsible** for obtaining any required authorizations from your PCP or health plan for treatment prior *to the visit. If you do not have the authorization, you may be financially responsible.*

Affix Patient Label

Patient Name:_____ DOB:_____

- Workers Compensation: If your claim has been accepted and services approved, your claim will be handled directly with your Workers Compensation carrier and no charges will be incurred by you. Your recovery and return to work takes a partnership with you, your case manager and us. If your claim is denied, charges become your responsibility.

- If the patient is a minor (18 years and younger), the parent or guardian must sign below. The parents, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary authorization and insurance card.

- Some services, such as preventive services, may not be a covered benefit under your insurance plan or under Medicare benefit guidelines. It is your responsibility to pay any balance not covered by your insurance plan.

- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card).

- We reserve the right to charge $25.00 for a cancellation within 24 hours of your appointment or failure to appear at your scheduled appointment time.

- Your bill may be amended if errors in billing are found.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements and available payment plans should be directed to the physician's office. We are here to help you.

Assignment

I authorize release to any third party payor such as an insurance company or governmental agency any medical information contained in my records when such material is required in connection with determining a claim for payment, and hereby assign all payments for medical services for myself and/or dependent to Bronson. I agree to pay for any charges not covered by my insurance.

_____ _____ _____

Signature of Responsible Party **Patient's Date of Birth** **Date**

Revised 4/07, 4/09, 11/09, 04/10, 10/11, 4/15

BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

BRONSON HEALTHCARE GROUP

Bronson Ambulatory Pediatric Consent to Treat

We or I _____, the Parent(s) or Guardian(s) or Power of Attorney of_____ give Bronson and its Employees the right to treat my son or daughter, or legal ward.

STATEMENT BY PARENT OR GUARDIAN AUTHORIZING AN ADULT OTHER THAN THEMSELVES TO OBTAIN TREATMENT FOR A MINOR CHILD

I hearby Authorize the ADULTS NAMED BELOW* (must be 18 years of age or older) to secure medical treatment necessary for the welfare of my child.

_____
Patient Name

1. _____
Authorized person Phone number Relationship to patient

2. _____
Authorized person Phone number Relationship to patient

3. _____
Authorized person Phone number Relationship to patient

BRONSON SHOULD BE MADE AWARE OF ANY SPECIAL CUSTODIAL RELATIONSHIPS. IF APPLICABLE, PLEASE EXPLAIN IN THE SPACE BELOW. DOCUMENTATION MAY BE REQUIRED.
(Example: parents are divorced but only one parent has guardianship, etc.)

_____
_____
_____
_____

IF YOUR CHILD IS UNDER 16 YEARS OF AGE:
Parent, Guardian, Power of Attorney or Authorized Adult should remain in the Therapy Department while the child is in Therapy.

IF YOUR CHILD IS OVER 16 YEARS OF AGE:
Do you Authorize the child listed above to Attend Bronson Appointments by himself/herself?(circle one)
YES NO

Legal Guardian/Parent Signature:_____ Date:_____ Time:_____
Emergency Contact Number:_____

BRONSON

Affix Patient Label

Name: _____ Date of Birth: _____

Authorization to Share Medical Information

☐ I authorize Bronson Healthcare Group to share my:

- ☐ Personal and/or demographic information
- ☐ Medical information – excluding _____
- ☐ Billing/financial/insurance information
- ☐ All information

To the following individuals:

Name	Relationship to Me
_____	_____
_____	_____
_____	_____
_____	_____

-OR-

☐ I do not authorize Bronson Healthcare Group to release any of my medical information to anyone, with the exception of coordination of benefits (i.e., insurance) or continuation of care (i.e., referrals).

This authorization will remain in effect until revoked in writing by the above listed patient.

_____ _____

Signature Date

BRONSON

Affix Patient Label

Patient Name:_____ Date of birth:_____

Diagnostic Use Authorization

Due to various insurance requirements, it is necessary for us to inform you of where your diagnostic test will be sent.

The tests may or may not be covered by your insurance plan. If you have any questions about your insurance coverage, please contact your insurance company prior to having these tests performed.

I acknowledge that all diagnostic specimens obtained in our office (ex: laboratory, pathology, cytology etc.) will be sent to Bronson Hospitals for processing.

_____

Patient Signature Date

BRONSON STATEMENT ON PATIENT RIGHTS AND RESPONSIBILITIES

Because Bronson respects the rights and human dignity of each patient, patient rights and responsibilities are given upon admission or upon request.

We are committed to making your experience at Bronson as positive as possible. If you have concerns, complaints, ethical issues or suggestions, please contact the Patient Relations Office at (269) 341-8959.

The Right to Information You Can Understand During Your Hospital Admission
You have the right to:

- Know about Bronson's policy of Patient Rights and Responsibilities and Advance Directives
- Contact a Bronson Patient Representative if there is a question, concern or complaint about any service
- File a grievance with the hospital or external agency and to be informed of the procedure for initiation, review and resolution of a grievance or complaint
- Know about services and the charges for services; to have your hospital bill explained; and to know about financial help offered by the hospital
- Know who is giving your care; to information about your health and treatment plan; to know about your future healthcare needs; and the right to be involved in discharge plans
- Agree to or refuse treatment; to be told the risks of treatment; and the right to be told what will happen if you refuse treatment; and know about Bronson's rules that affect patient care and conduct
- Receive visitors that you designate, including, but not limited to, a spouse, a domestic partner (including the same-sex domestic partner), another family member, or a friend. You also have the right to withdraw or deny such consent at any time.
- Language assistance services

The Right to Dignified, Respectful, Considerate Care
You have the right to:

- Care regardless of age, race, color, creed, national origin, sex, religion, marital status, sexual orientation, gender identity, disability or your ability to pay for care
- Be free from mental or physical mistreatment; be free from restraints unless ordered by a physician for your safety or the safety of others. If restraint is used, the least restrictive method will be used and it will be stopped as soon as possible.

The Right to a Reasonable Response to Your Requests
You have the right to:

- Have a reasonable response to your needs for treatment and service within Bronson's ability
- Request generic or trade brand drugs
- Have your civil and religious rights and your cultural and spiritual beliefs respected to the extent that they do not interfere with the well being of others

The Right to Personal Privacy and Confidentiality of Your Medical Treatment and Medical Records
You have the right to:

- Have your personal and medical records treated with privacy; to review your medical record; and to obtain a copy of your medical record. Your record cannot be given to anyone without your permission, unless required by law, third party payment contract, or hospital accrediting agency.
- Talk privately with your physician, attorney or other person
- Send and receive unopened personal mail
- Be treated in private; to be cared for with dignity and as an individual.

The Right to be Informed of Any Research or Educational Projects Affecting Your Care or Treatment
You have the right to:

- Information about experimental treatment considered in your care; and to know the risks and possible result of refusing this treatment
- Be informed if you are part of an educational project as Bronson is a teaching hospital.

Patient Responsibilities Which Will Promote a True Partnership in Your Treatment:

- Make available a complete and correct medical history
- Let us know if you understand your medical treatment
- Take part in healthcare decisions with the advice of your doctor(s) and follow the recommendations and advice of your doctor(s)
- Tell your doctor or nurse about any problems you have during your medical treatment
- Be considerate of the rights of other patients, Bronson staff, and property
- Give correct information about how you will pay your bill
- Make arrangements to pay bills not paid by your insurance
- Follow Bronson's rules about patient care and conduct

Bronson Statement on Pain Management
We believe all patients have a right to pain relief.
Based on this belief we will:

- Tell patients that pain relief is an important part of their care
- Review patient's pain on the first evaluation
- Continue to look at the presence, quality and intensity of pain
- Consider pain monitoring the fifth vital sign and monitor pain often based on the patient's condition and pain state
- Use what the patient says about their pain as the primary indicator of pain
- Accept with respect the reports a patient makes about pain
- Respond quickly to reports of pain
- Consider the special needs of children, frail and elderly patients in the assessment and treatment of pain
- Work with the patient, family and other healthcare providers to establish a goal for pain relief
- Develop and use a plan to make pain relief the goal, including education of the patient and family
- Continue to review and change the care for patients who have pain that will not stop.

If your concern is not resolved through Bronson, you may file a complaint via:

Michigan Department of Community Health
Bureau of Health Services
Complaint Investigation Unit
P.O. Box 30664
Lansing, MI 48909
(800) 882-6006
michigan.gov/mdch

The Joint Commission
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(800) 994-6610
(630) 792-5636 fax
Email: complaint@jointcommission.org

KEPRO Rock Run Center,
Suite 100
5700 Lombardo Center Drive
Seven Hills, OH 44131
(855) 408-8557
(844) 834-7130 fax
keproqio.com

Visita bronsonhealth.com/en-espanol.

BRONSON

It's OK to Ask

Please ask questions and talk with your doctors, nurses and other care providers during your office visit. Talking together helps make sure you and your family member get the best care possible. There are several areas that Bronson would like you to pay close attention to:

- Medications
  - Bring a list of all your medicines, over-the-counter drugs, herbal supplements and vitamins to your appointments every time.
  - Ask your doctor for your medication refills during your office visit. This will help make sure you take your medication without any breaks.
  - Tell your doctor and nurse about your allergies.
  - Ask your doctor about each drug she prescribes and what it is used for. Make sure the doctor writes the name of the drug clearly so you and the pharmacist can read it. Ask to take home written information on why you are taking the medicine and possible side effects.
  - Anytime you receive a medicine, shot or intravenous (IV) fluid, the nurse or other provider should ask for your name and birthdate. This makes sure the right medication is given to the right patient.

- Help Prevent Infections
  - Ask everyone who enters your room to wash their hands or use hand sanitizer. This helps to keep you safe from other people's germs.
  - Make sure to get your flu or pneumonia vaccine.

- Testing
  - Ask your doctor what the tests are for and what to expect.
  - Find out how and when you will be told about your test results.
  - Call the office if you do not receive your test results when you were expecting them.

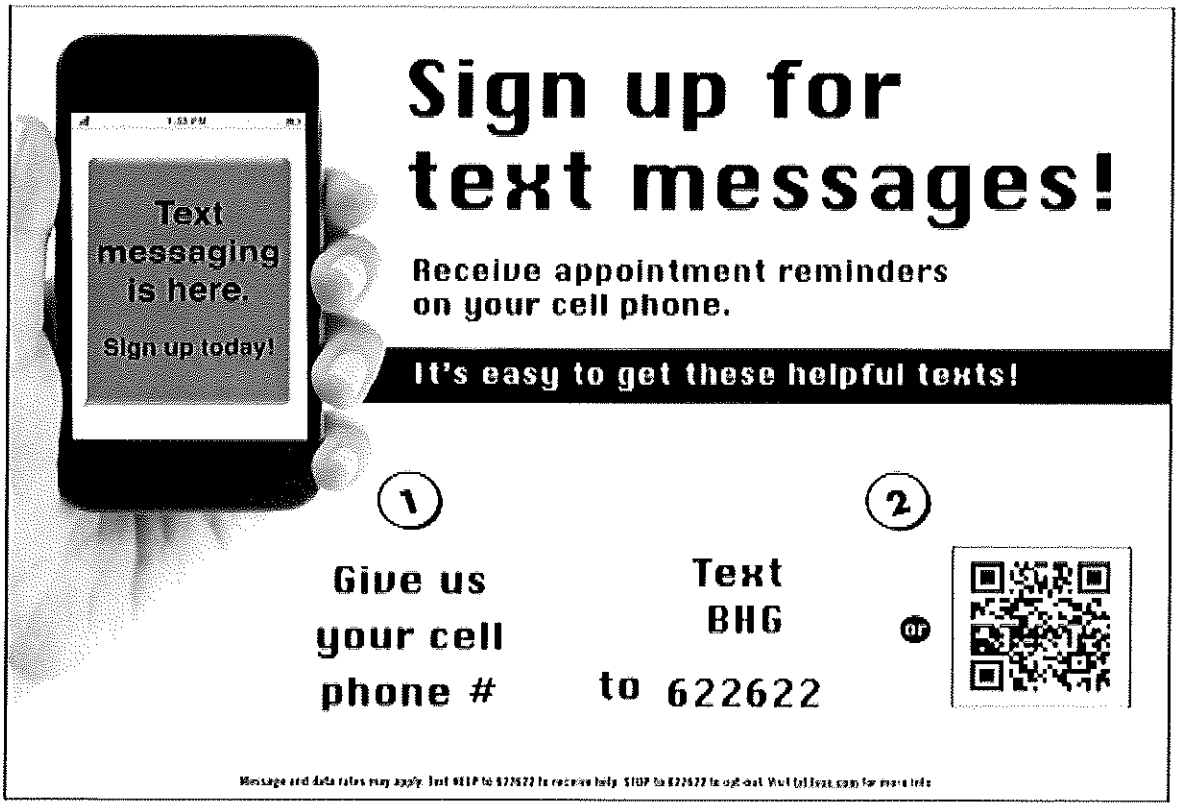
- Pain Management
  - Tell your doctor or nurse if you are uncomfortable or in pain. Most pain can be controlled and will be addressed right away. It is OK to ask again if you feel your pain has not been addressed.

- Help Prevent Falls
  - Always wear non-skid footwear to your appointment.
  - Use office floor mats to wipe wet bottoms of shoes.
  - Get up slowly from the exam table or chair to help prevent dizziness.
  - When recommended, use a walker, crutches, cane or wheelchair.
  - Stand next to your child when they are on the exam table.

Patients and their families are the most important partners on the healthcare team. We want you to ask questions, give information, and help make decisions about your care.

BRONSON

Bronson's Appointment Text Reminder Message



Text Messaging Opt-In QR Code

HouseCalls
AUTOMATED MESSAGING SYSTEM

549769 - Bronson Healthcare Group-Appts

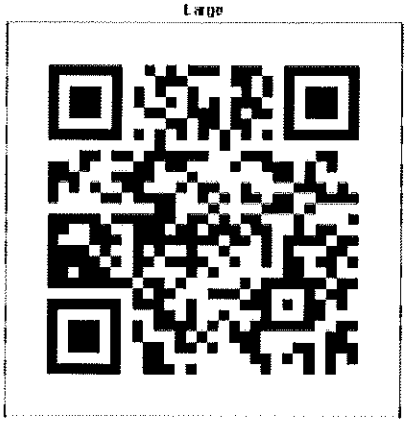
Short Code: 622622

Opt-In Keyword: BHG

Small

Medium

Large



Text BHG to 622622 or scan the barcode and opt in with BHG

BRONSON