Calumet
56720 Calumet Ave.
Calumet, MI 49913
(906) 483-1177

Gwinn
135 East M-35
Gwinn, MI 49841
(906) 346-9275

Hancock
500 Campus Drive
Hancock, MI 49930
- Family Practice
(906) 483-1060
- Pediatrics
(906) 483-1700
- Obstetrics & Gynecology
(906) 483-1050

Houghton
600 MacInnes Drive
Houghton, MI 49931
(906) 483-1860

Lake Linden
945 Ninth Street
Lake Linden, MI 49945
(906) 483-1030

Menominee
1110 10th Avenue
Menominee, MI 49858
(906) 290-5000

Ontonagon
751 S. Seventh Street
Ontonagon, MI 49953
(906) 884-4120

Iron River
1500 W. Ice Lake Road
Iron River, MI 49935
(906) 265-5378

Sawyer
301 Explorer Street
Gwinn, MI 49841
(906) 346-9275

Dear Parents,

On behalf of the Upper Great Lakes Health Center (UGL), we welcome parents and understand we have an important role as the campus medical and wellness home for MTU students. We encourage parents to coach their students toward making wise health choices and through getting health care, when needed. Please know we offer services specifically for students conveniently located right on campus in the Student Development Center (SDC)

UGL's Houghton Family Health Center and UP Health System – Portage have partnered to provide Michigan Tech's student health services. Here are some of the services we offer.

- Primary Care Services
- Online Scheduling - https://uglhealth.org/online-scheduling/
- Woman's Health
- Birth Control/Sexual Health/STI
- (HRT) Hormone Replacement Therapy
- Behavioral Health/LMSW
- ADHD Care/Referrals
- Physical/Occupational Therapy
- (OMT) Osteopathic Manipulation Treatment
- Pharmacy
- Labs
- X-Ray
- Sports Medicine Services
- Care for Acute Injuries or illnesses Including Same Day Walk – In Availability
- Allergy Injections/Medication Administration
- Annual Flu Shots and other Routine Immunizations
- Coordination of Student Health Care with other Healthcare Providers
- Referral to Outside Specialists for Specific Health Needs

This time of transition is exciting and sometimes unsettling. Students may be navigating the healthcare system for the first time without parents, and you can trust that we understand what that is like for each of you. I assure you that the health center staff is prepared to serve as the student's health and wellness home away from home**. Please join us for an Open House located at the Houghton Clinic on August 18th from 10 am – 12 pm.**
We have included our new patient packet to help gather needed health information and allow for a seamless transition of care to UGL. If you have any questions, please feel free to call our clinic directly at (906)-483-1860.
Sincerely,

UGL Staff

Upper Great Lakes
Family Health Center
Houghton

600 MacInnes Drive
Houghton, MI 49931
906-483-1860
www.uglhealth.org

Meet Our Providers

Bruce Trusock, MD
Family & Sports Medicine

Todd Anderson, DO
Family Medicine

Karen DeYoung, DO
Family Medicine

Zachariah DeYoung, MD
Family & Sports Medicine

Melissa Vertin, PA
Family & Sports Medicine

Stephanie McKenzie, PA
Family Medicine

Kathryn Kass, PA
Family Medicine

Call 906-483-1860 to schedule your appointment today!

UPPER GREAT LAKES FAMILY HEALTH CENTER-REGISTRATION FORM

General Information

First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
County: Home Phone:	Cell Phone:	Work Phone:	
Birthdate: Social Security #: _____-____-_____	Do you have paperwork about your end of life wishes? __Yes __No		

Email address: Do you want to participate in our Patient Portal? __Yes __No

What is the best way to reach you? ❑ cell phone ❑ home phone ❑ text ❑ email ❑ other _____
Can we text you appointment reminders? ❑ Yes ❑ No

Marital status?	❑ Married ❑Single ❑Widowed ❑Divorced ❑Separated
Do you work in Agriculture?	❑ Migrant Worker ❑Seasonal Worker ❑None
Employer: Occupation:	Do you work: ❑Full time ❑Part time ❑Unemployed ❑Retired

Our Policy

It is the policy of UGL to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race: ❑White ❑Asian ❑ Black/African American ❑Native Hawaiian ❑Pacific Islander ❑Other:
❑Native American/ Alaska Native – Tribal Member: ❑ Yes ❑ No Descendent: ❑ Yes ❑No Name of Tribe:

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic or Latino ❑Other: _____ Preferred Language:

Are you a veteran? ❑ Yes ❑ No Are you homeless? ❑ Yes ❑ No Do you need an Interpreter? ❑ Yes ❑ No

Sexual Orientation:	☐ Straight	☐ Bisexual	☐ Lesbian/Gay	☐ Something Else	☐ Don't Know	☐ Choose not to disclose
Gender Identity:	☐ Male	☐ Female	☐ Transgender Male	☐ Transgender Female (male to female)	☐ Other	☐ Choose not to disclose

Insurance Information

Do you currently have health insurance? ❑Yes ❑No (Please also send a copy of insurance card(s) to billing@uglhealth.org)

Dental Insurance? ❑Yes ❑No

If no we will schedule an appointment with our outreach and enrollment team to help you.

Name of Individual Responsible for the Bill:		Relationship:	
Subscriber No.:	Group No.:		
Policyholder's Name:	Birthdate:	Social Security #:_____-____-_____	
Mailing Address:	City:	State:	Zip:
Phone:	Which **PHARMACY** do you use?	Ph#:	

Income Information

Federal Regulations require that we report the *combined total* of all household members' income for those seeking care at UGL. We ask your cooperation in indicating the following: Total Number in Household_____

Your yearly combined household gross income? _____ Decline to answer _____

Even if you have insurance, you may qualify for UGL's sliding fee scale, which offers discounted fees for services. Do you want to apply to see your qualification? ❑Yes ❑No

Emergency Contact Information

Name:		Relationship:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

Thank you for completing this application form and for your interest in joining the Upper Great Lakes Family Health Center, Inc. community of care.

UPPER GREAT LAKES FAMILY HEALTH

Patient Name: _____

DOB: _____

Patient Email and Text Message Informed Consent

Upper Great Lakes Family Health Center (UGLFHC) and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "UGLFHC") may communicate with you by e-mail, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. This form provides information about UGLFHC' use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for UGLFHC' communication with you by Electronic Messaging.

How we will use Electronic Messaging: UGLFHC may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
- how to participate in patient satisfaction surveys or how to use our secure patient portal (Healow); and
- information regarding insurance, billing, eligibility for programs/benefits, and account balances.

UGLFHC may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has numerous risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: UGLFHC cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal, MyChart.
- Electronic Messaging may be filed into your medical record.
- UGLFHC is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: You may choose to stop participating in Electronic Messaging at any time by informing UGLFHC in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact the UGLFHC Privacy Officer as described in the Notice of Privacy Practices.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between UGLFHC and me, and I consent to the conditions and instructions outlined, as well as any other instructions that UGLFHC may impose to communicate with me by Electronic Messaging.

I understand that UGLFHC will send Electronic Messaging to those telephone number(s) and email address(es) in my account.

If I decide to opt-out of Electronic Messaging, I will indicate as such below or submit my wishes in writing to UGLFHC.

☐ I choose to opt-out of receiving **text messages**

☐ I choose to opt-out of receiving **e-mail messages**

Release. In consideration of UGLFHC' services and my request to receive Electronic Messaging as described herein, I hereby release UGLFHC from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

_____ _____ _____

Patient (or Authorized Representative) Signature **Patient's Printed Name** **Date**

PATIENT CONSENT TO VERBALLY DISCUSS INFORMATION

I hereby agree and consent to Upper Great Lakes Family Health Center staff verbally discussing medical and financial information about my healthcare with the following individual(s):

PLEASE PRINT: First and Last Name	**Relationship to Patient**
PLEASE PRINT: First and Last Name	**Relationship to Patient**
PLEASE PRINT: First and Last Name	**Relationship to Patient**
PLEASE PRINT: First and Last Name	**Relationship to Patient**
PLEASE PRINT: First and Last Name	**Relationship to Patient**

This consent is valid for one year from date of signature unless I notify Upper Great Lakes Family Health Center in writing of my withdrawal.

I hereby release Upper Great Lakes Family Health Center from all legal responsibility or liability that may arise from the acts that I have authorized above.

PLEASE PRINT: Patient's First and Last Name	**Patient's DOB**
Patients Signature	**Date**

*If patient is less than 18 years of age, then permission is granted by the following parent and/or legal guardian of above-named minor:

PLEASE PRINT: Parent or Guardian's First and Last Name	**Date**

*** Parent or Guardian's Signature**

301 Explorer Street
Gwinn, MI 49841
Phone: (906) 346-9275 | Fax: (906) 372-3230
Email: him@uglhealth.org

Patient Authorization for Disclosure of Health Information

(Patient Name) _____ (Date of Birth) _____ (Maiden/Previous Name) _____ (Patient Phone #) _____

Records to Be Disclosed From:

Organization/ Individual: _____

Address: _____

_____

Phone: _____

Fax: _____

Disclose Records To:

Organization/ Individual: _____

Address: _____

_____

Phone: _____

Fax: _____

Covering the Period of Healthcare from:

Date(s): _____ to _____

OR

☐ All Past/Present Health Information

Information to Be Disclosed:

- ☐ Entire Health Record
- ☐ Medical Progress Note(s)
- ☐ Immunization Record
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Dental Record(s)
- ☐ Dental Imaging
- ☐ Other: _____

Purpose of Disclosure (check all that apply):

- ☐ At the Request of Patient
- ☐ Continued Care
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Worker's Comp
- ☐ Relocating
- ☐ Personal Use
- ☐ Other: _____

Disclosure Format:

- ☐ Fax
- ☐ Electronic (Patient Portal)
- ☐ Paper-Pickup in Person
- ☐ Paper-US Mail
- ☐ Other: _____

By signing this authorization form, I understand that:

i) The information to be disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or other communicable diseases. It may also include information about behavioral or mental health services, treatment and/or testing for substance use disorders, and genetic testing.

1) Any sensitive information listed above I wish to be EXCLUDED will be indicated here:_____

ii) Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

iii) I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 301 Explorer Street, Gwinn, MI 49841. Revocation will not apply to information that has already been disclosed in response to this authorization.

iv) Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.

v) Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

vi) Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules

_____ _____

(Patient or Authorized Representative Signature) (Date)

_____ _____

Print Name Relationship to Patient (if applicable)

(For Office Use Only): Received On: _____ *Verified By:* _____

Revised: 01/28/22

Corporate Office
506 Campus Drive
Hancock, MI 49930
Phone: (906) 483-1705
Fax: (906) 483-1394

Sliding Fee Program

What is the Sliding Fee Program? The Sliding Fee Program is a federally funded program that provides a discount to patients who are uninsured or underinsured. This program allows qualifying patients to receive Medical, Dental and Behavioral Health services at Upper Great Lakes Family Health Centers (UGL) at a discounted fee after any insurance, if applicable, has processed the claim. There is a minimum amount due at the time of service for all discounted services received.

Who is eligible for the Sliding Fee Program? Uninsured and underinsured patients may qualify for the Sliding Fee Program. Patients currently enrolled in other discounted health care programs such as the Western Upper Peninsula Health Access Coalition (WUPHAC), Marquette County Access Coalition or local Charitable Care Programs are encouraged to apply. Federal guidelines require us to take household size and household income into consideration when determining an applicant's eligibility.

Where does the Sliding Fee Program apply? The Sliding Fee Program applies to qualifying patients who receive services at any of these Upper Great Lakes Family Health Center sites:

****Calumet**
56720 Calumet Ave.
Calumet, MI 49913
(906) 483-1177

Gwinn
135 East M-35
Gwinn, MI 49841
(906) 346-9275

***Hancock**
500 Campus Dr.
Hancock, MI 49930
Family Practice (906) 483-1060
Pediatrics (906) 483-1700
OB/GYN (906) 483-1050

Houghton
600 MacInnes Dr.
Houghton, MI 49931
(906) 483-1860

Iron River
1500 W. Ice Lake Rd.
Iron River, MI 49935
(906) 265-5378

Lake Linden
945 Ninth St.
Lake Linden, MI 49945
(906) 483-1030

Menominee
1110 10th Avenue
Menominee, MI 49858
(906) 290-5000

Ontonagon
751 S. Seventh St.
Ontonagon, MI 49953
(906) 884-4120

****Sawyer**
301 Explorer St.
Gwinn, MI 49841
(906) 346-9275

Marquette
1414 W. Fair Ave, Suite 242
Marquette, MI 49855
(906)-449-2900

Revised 01/16/2023

UPPER GREAT LAKES
FAMILY HEALTH

Corporate Office
506 Campus Drive
Hancock, MI 49930
Phone: (906) 483-1705
Fax: (906) 483-1394

***Hancock Location:** Includes clinic services received in Family Practice, Pediatrics and OB/Gyn.
****Dental Services** available at these locations; Calumet and Sawyer.

When should you apply for the Sliding Fee Program? You should apply immediately to see if you qualify for the Sliding Fee Program. If approved for the program, you will be required to renew your application and information on an annual basis. If you are not approved for the program, you are encouraged to contact us if you have a significant change in income or family size as we may be able to re-evaluate your information.

How can I apply for the Sliding Fee Program? You may apply for the Sliding Fee Program by submitting the following:

* Completed and signed Sliding Fee Program Application (enclosed)
* Proof of Income
  - Income is defined as any money received whether cash, check, or direct deposit used to support your household. Income can include wages, unemployment, pension, social security, disability, child support, gambling winnings and cash payment for services rendered or payment for other reasons.
  - Households claiming zero income will be required to provide a signed statement explaining the current financial situation so staff members are able to determine if a discount can be approved.

Enclosed is an application for the Sliding Fee Program. Please complete, sign and return your application and proof of income to the location of your preferred health center above. If you have further questions please contact a Financial Counselor at 906-483-1130 opt. 2. Once received, your completed application will be reviewed by a member of our staff who will then send you a letter regarding your eligibility.

Please note: All of the above information must be received in order to process your application. Submitting incomplete or partial information will delay a decision until additional requested information is received. Until you receive a letter indicating you have qualified for a discount, you are responsible for 100% of all charges.

Sincerely,

Upper Great Lakes Family Health Center Staff

*Please note: If approved for the Sliding Fee Program, **limited** Diagnostic and Radiology services are available to you at a discounted rate*

Revised 01/16/2023

UPPER GREAT LAKES
FAMILY HEALTH

Corporate Office
506 Campus Drive
Hancock, MI 49930
Phone: (906) 483-1705
Fax: (906) 483-1394

Sliding Fee Application

Head of Household

_____
(please print) Last Name First Name Middle Initial

Mailing Address_____
Street City Zip

Telephone __(_____)_____ Date of Birth_____

Pharmacy _____ Social Security Number_____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Household Members

Please print information below for ALL other persons living in your household

Full Name	Date of Birth	Relationship	Insurance Y/N

*Medical Insurance Name _____Subscriber Name_____

Policy Number_____ Group Number_____

*Dental Insurance Name_____ Subscriber Name_____

Policy Number_____ Group Number_____

Revised 01/16/2023

UPPER GREAT LAKES
FAMILY HEALTH

Corporate Office
506 Campus Drive
Hancock, MI 49930
Phone: (906) 483-1705
Fax: (906) 483-1394

Income Verification

Please provide proof of income for all members living within your household. Supporting documentation must show gross pay (total of income before any deductions), cover 4 consecutive weeks of pay and indicate the length of the pay period covered. Examples include:

- Most Recent Tax Return
- Check Stubs
- Social Security Income*
- Disability Income
- Child Support
- Unemployment Income
- Pension
- Retirement Income

*If you receive Social Security benefits, please provide the letter you received from the Social Security Administration stating the amount you receive each month. If you are unable to provide the letter, we will accept your last two months of bank statements showing the deposit along with a signed note stating the amount that is taken out for Medicare Part B & D.

Households claiming zero income will be required to schedule an appointment with a Financial Counselor to determine eligibility.

I verify that this information presented in this application to be true and accurate to the best of my knowledge and my signature below verifies that I am applying for a Sliding Fee Program discount. Furthermore, I understand that I am responsible for 100% of any charges incurred prior to being deemed eligible to receive a discount through the Sliding Fee Program.

Signature _____ Date_____
Head of household

Signature _____ Date_____
Spouse or other adult household member

Revised 01/16/2023

UPPER GREAT LAKES
FAMILY HEALTH

Corporate Office
506 Campus Drive
Hancock, MI 49930
Phone: (906) 483-1705
Fax: (906) 483-1394

Upper Great Lakes Family Health Center, INC

DEPARTMENT OF HEALTH & HUMAN SERVICES POVERTY GUIDELINES

EFFECTIVE 01/16/2023

		Less than A	More than A Less than B	More than B Less than C	More than C Less than D	More than D
Medical Services		**$25 Nominal Charge***	**$50 Discounted Fee***	**$75 Discounted Fee***	**$100 Discounted Fee***	**No Discount**
Behavioral Health		**$10 Nominal Charge**	**$30 Discounted Fee**	**$50 Discounted Fee**	**$70 Discounted Fee**	**No Discount**
Dental Services		**$30 Nominal Charge***	**40% of Total Charge***	**50% of Total Charge***	**60% of Total Charge***	**No Discount**
HOUSEHOLD SIZE		**A**	**B**	**C**	**D**	**E**
	YEAR	14,580.00	18,225	25,515	29,160	29,160.01
1	MONTH	1,215.00	1,519	2,126	2,430	2,127.01
	WEEK	280.38	350	491	561	491.01
	YEAR	19,720.00	24,650	34,510	39,440	39,440.01
2	MONTH	1,643.33	2,054	2,876	3,287	2,873.01
	WEEK	379.23	474	664	758	663.01
	YEAR	24,860.00	31,075	43,505	49,720	49,720.01
3	MONTH	2,071.67	2,590	3,625	4,143	3,620.01
	WEEK	478.08	598	837	956	835.01
	YEAR	30,000.00	37,500	52,500	60,000	60,000.01
4	MONTH	2,500.00	3,125	4,375	5,000	4,367.01
	WEEK	576.92	721	1,010	1,154	1,008.01
	YEAR	35,140.00	43,925	61,495	70,280	70,280.01
5	MONTH	2,928.33	3,660	5,125	5,857	5,113.01
	WEEK	675.77	845	1,183	1,352	1,180.01
	YEAR	40,280.00	50,350	70,490	80,560	80,560.01
6	MONTH	3,356.67	4,196	5,874	6,713	5,860.01
	WEEK	774.62	968	1,356	1,549	1,352.01
	YEAR	45,420.00	56,775	79,485	90,840	90,840.01
7	MONTH	3,785.00	4,731	6,624	7,570	6,607.01
	WEEK	873.46	1,092	1,529	1,747	1,525.01
	YEAR	50,560.00	63,200	88,480	101,120	101,120.01
8	MONTH	4,213.33	5,267	7,373	8,427	7,353.01
	WEEK	972.31	1,215	1,702	1,945	1,697.01
For each additior	YEAR	5,140.00	6,425	8,995	10,280	10,280.01
person, add	MONTH	428.33	535	750	857	747.01
	WEEK	98.85	124	173	198	172.01

Upper Great Lakes Family Health Centers defines "household" as: ALL THE PERSONS WHO OCCUPY A HOUSING UNIT WHETHER THEY ARE RELATED TO EACH OTHER OR NOT. REVS'D 01/16/23

UGL defines "income" as TOTAL CASH RECEIPTS (WAGES, SALARIES, PUBLIC ASSISTANCE/ UNEMPLOYMENT/RETIREMENT PAYMENTS, SOCIAL SECURITY, ALIMONY, CHILD SUPPORT.) BEFORE TAXES. However, income does not include non-cash benefits (food stamps, school lunches, or food/rent in lieu of wages). Income include gifts.

***Services that include materials, devices and/or lab costs will be in addition to the nominal fee.**

Revised 01/16/2023