MACOMB PHYSICIANS GROUP, PLLC

PATIENT DEMOGRAPHICS

Last Name _____ M.I. _____

First Name _____

Street Address _____

City _____ State _____

Zip Code _____

Email _____

Gender: ☐ Male ☐ Female

DOB: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

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

LANG

☐ English ☐ Spanish ☐ Other: _____

ETHNIC GROUP

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined To State

RACE

☐ African American/Black ☐ Pacific Islander
☐ Asian ☐ White or Caucasian
☐ Asian Indian ☐ Filipino
☐ American Indian or Alaska Native ☐ Other
☐ Declined To State

GUARANTOR (RESPONSIBLE PARTY)

☐ Same as Patient **PLEASE COMPLETE IF DIFFERENT FROM PATIENT**

Name: _____
Last Name *First Name*

DOB: _____

Address: _____
Street Address

_____
City *State* *Zip*

EMPLOYER

☐ Employed ☐ Unemployed ☐ Retired

Name: _____

Address: _____

_____

Phone: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

Please notify the front desk staff if you have three insurances

PRIMARY INSURANCE

Cardholder Name: _____ Insurance Co.: _____

Cardholder Gender: ☐ Male ☐ Female Cardholder Date of Birth: _____

Relationship: _____

SECONDARY INSURANCE

Cardholder Name: _____ Insurance Co.: _____

Cardholder Gender: ☐ Male ☐ Female Cardholder Date of Birth: _____

Relationship: _____

I would like information on Patient Advocacy: ☐ **Yes** ☐ **No**

- Patient must present their insurance ID card and photo ID to the receptionist for copying purposes.
- Copayments are due at the time of service.
- I authorize the use of my signature on all insurance claims.
- I authorize the release of any medical information to my insurance company and or other health providers.
- I authorize my insurance company to pay directly to the doctor.
- I understand that I am responsible for payments of all services not covered by my insurance company.

Signature of patient or legal representative X _____ Date _____

Authorization to Discuss and/or Release My Private Medical Information

I authorize Macomb Physicians Group PLLC, its physicians or staff to discuss the information contained in my medical record, or provide copies of my private medical information to the following person or persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is effective as of the date signed. I understand that I may revoke this agreement in writing at any time.

It is understood that in the event of my demise, my private medical information will be released to the individual who is named as my power or attorney, personal representative, or by a properly executed order from a court.

Patient's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Notice of Privacy Practices Acknowledgement

Our Commitment:

- We understand the importance of safeguarding your Protected Health Information (PHI).
- We value your trust and will continue to recognize the importance of holding your PHI as confidential.
- We will hold our employees to strict standards of conduct to ensure the confidentiality of your PHI.
- We maintain physical, electronic and procedural safeguards to comply with state and federal regulations pertaining to PHI.

Our Privacy Notice telling you how this office uses & discloses PHI and what your rights are is posted in the lobby.

(A copy of the Notice of Privacy Practices is available on request)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Macomb Physicians Group, PLLC

Patient Consent Form

Please review this form carefully and sign where indicated. This consent is required to render medical services and to obtain payments from your insurance carrier(s). Please ask our staff member if you have any questions regarding the contents of this form.

PERMISSION TO EXAMINE AND TREAT:
I hereby give my permission to Macomb Physicians Group, PLLC. It's physicians and staff to obtain medical history, carry out medical examination, and or procedures needed to make a diagnosis and offer medical treatment.

REFUSAL OF MEDICAL TREATMENT:
I understand that I have a right to refuse any and all medical treatments and recommendations. I shall take full responsibility of my actions in case of refusal of treatment or not following medical recommendations.

FINANCIAL RESPONSIBILITY:
I understand that I am financially responsible for all the charges whether or not they are covered by my insurance carrier(s). I also understand that some insurance do not cover routine examinations, annual physicals, school physicals and third party examinations. I agree to pay any co-payments, deductibles and/or services not covered by my insurance carrier on the date of service.

Macomb Physicians Group, PLLC will submit a claim to your insurance carrier(s) on your behalf, if correct insurance information is provided on the date of service. If we are unable to collect on your outstanding debt with in a reasonable time we shall hand over your account to a collection agency and dismiss you as a patient of our medical practice.

LABORATORY TESTS:
I authorize Macomb Physicians Group, PLLC, to send my blood/urine etc. specimens to an outside laboratory for testing. I understand that I shall be financially responsible for payments of the laboratory services that are not covered by my insurance carrier(s). I understand that bills for unpaid laboratory services will come from the laboratory where my specimens were sent.

ASSIGNMENT OF BENEFITS:
I hereby assign, transfer, and set over Macomb Physicians Group, PLLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. A photocopy of this document shall be considered as effective and valid as original. Medicare assignment of benefits will apply accordingly. This authorization shall remain valid until a written notice is given by me revoking said authorization.

AUTHORIZATION TO RELEASE MEDICAL RELATED INFORMATION:
I authorize release of medical information needed to determine my medical reimbursement benefits. (Your insurance may request such information to prove that you were seen in the office. In Michigan, we are required to provide this information by law.)

SUMMARY:
We may treat you
You may refuse treatment
You permit us to bill your insurance
Ultimately you are responsible for the payments
Laboratory tests go to outside facilities

Signature: _____ Date _____
(Patient or Guardian)

Relationship to patient if you are a guardian: _____

FINANCIAL POLICY – Macomb Physicians Group, PLLC

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. We do ask for a copy of an ID card/license due to the many cases of identity theft in the news lately.

2. **INSURANCE:** We are participating providers with many insurance plans. We will file all of these insurance claims for you. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a $40 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the service fee and collections action. All bad checks written to this office are subject to collections.

4. **ACCOUNTING PRINCIPALS:** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. **FORMS FEES:** completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Postage is additional and payment is required in advance. Copying fees for Medical Records are updated annually and are based on the Consumer Price Index of Medical Records Access Act Fees from the State of Michigan's Department of Community Health.

6. **MISSED APPOINTMENTS:** if you no-show, we will assess you a $25 missed appointment fee.

7. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to **MPG** for charges not covered by the assignment of insurance benefits.

8. **ASSIGNMENT OF INSURANCE BEBEFITS:** I hereby assign, transfer, and set over directly to **MPG** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize MPG to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to MPG. I authorize MPG to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

9. **RELEASE OF INFORMATION:** I hereby authorize and direct **MPG** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

10. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print the name of the patient

Macomb Physicians Group, PLLC.

Health History

Name:_____ **Age:**_____ **Today's Date:** ____ / ____ / 20____

Marital status: ☐ Single, ☐ Married, ☐ Separated, ☐ Divorced, ☐ Widowed.

Check all items either yes or no	NO	Yes New	Yes Old	Date	Check all items either yes or no	NO	Yes New	Yes Old	Date
Anemia					*Arthritis*				
Angina					*Asthma / Hay Fever*				
Heart attacks / By pass					*Blood Diseases*				
Diabetes					*Cataracts*				
High Blood Pressure					*Bronchitis / Emphysema*				
Elevated Cholesterol					*Liver Disease / Cirrhosis*				
Strokes / Mini strokes					*Colitis*				
Blocked Arteries in Leg or Neck					*Diverticulosis*				
Thyroid disease					*Gall Stones*				
Blood clots in legs / Lungs					*Stomach Ulcers / Reflux disease*				
Migraine Headaches					*Kidney Stones*				
Recurrent Sore Throat / Sinusitis					*Skin diseases / Psoriasis / Eczema*				
Heart Valve problems					*Blood in Stool or Urine*				
Hepatitis					*Night Sweats*				
Glaucoma					*Memory Loss*				
Epilepsy / Seizures					*Leg pain during walking*				
Alcohol / Drug abuse treatment					*Chest pain*				
Broken Bones / Joint Surgery					*Shortness of Breath*				
Cancer - Site:					*Weight loss / Weight Gain*				

Habits History

Habits	Yes	No	Amount		Habits	Yes	No	Amount
Smoke			_____ Packs / Day		Liquor			_____ Oz / Day
Coffee			_____ Cups / Day		Marijuana			_____ Joints / Week
Beer			_____ Cans / Day		Drugs			Name: _____

Family History

Check condition and relationship of the relative	Yes	No	Father	Mother	Brother	Sister	Son	Daughter	Check condition and relationship of the relative	Yes	No	Father	Mother	Brother	Sister	Son	Daughter
Diabetes									Mental illness								
Hypertension									Alcoholism								
Stroke									Obesity								
Heart attack age below 55																	
Emphysema																	
Colon Cancer																	
Breast Cancer																	

Medication and Allergy History

Medications (Long term only)	Dose	Allergy to medication	Type of reaction (Rash, Itching, Choking, Passed Out)
		No Allergy	
		Penicillin	
		Sulfa	
		See List	

I acknowledge that above information is correct to the best of my knowledge. I will not hold Macomb Physicians Group, PLLC or members of its staff responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of the Person or Guardian Date Signed