ENVISION MEDICAL GROUP – PATIENT REGISTRATION FORM

Today's Date:	PCP:	PCP PHONE:

PATIENT INFORMATION

Suffix:	Last Name:	First:	Middle:
Birth Date:	Age:	Sex:	SSN#:
Marital Status:	Ethnicity:	Preferred Language:	Race:
Address:		Primary Ph:	Secondary ph :
Email (For secure access to your records):		**Preferred Contact:**	
Primary Pharmacy:		Phone:	City:
Cross streets:			
Secondary Pharmacy:		Phone:	City:
Cross streets:			

GUARANTOR INFORMATION

Name:	**Gender:**	**DOB:**
Address:	**Phone:**	**Relationship:**
Policy Holder Name:	**Policy Holder DOB:**	

IN CASE OF EMERGENCY

Name of local friend or relative (primary):	Relationship to patient:	Home ph:	Work ph:
Name of local friend or relative (primary):	Relationship to patient:	Home ph:	Work ph:

The above information is true to the best of my knowledge. I authorize the release of any medical information, including information to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I authorize payment directly to Envision Medical Group, PLLC for services rendered. I understand that I am responsible for services performed without a valid HMO authorization form from my primary care physician, if my insurance does not guarantee coverage and/or payment. I further understand that I am responsible for payment of services rendered whether denied by my insurance company or in the case I have no insurance coverage.

Patient/Guardian signature *Date*

ELECTRONIC MEDICATION TRANSMISSION AUTHORIZATION

Your signature below authorizes EMG to download your medication history from the national SureScripts database and submit medication requests to the pharmacy using SureScripts clearinghouse.

Patient/Guardian signature *Date*

Privacy Notice: Envision Medical Group, PLLC ("EMG") is required by law to maintain confidentiality of patient health information (PHI). EMG works hard to ensure PHI is kept confidential and will NOT share PHI with individuals/entities not involved in services provided by EMG. (For a copy of EMG's Privacy Practices please check with your provider or contact our corporate offices at (248) 471-0675.) EMG will NOT distributed your email address for any reason.

Envision Medical Group Financial Policy

Dear Patients:

We are providing this for your review and acknowledgement. Please sign below where indicated.

Insurance: We participate in most insurance plans, including Medicare and other governmental agencies. You are responsible for ensuring our office has the most up to date insurance information. Please make sure you know your co-pay and deductible, and what is covered by your insurance carrier. Contact your insurance carrier with any questions you may have regarding your coverage. You will be responsible for any balance, as determined by your insurance carrier.

Self-Pay Patients/Patient responsibility payments: Patients without insurance and patients with beginning of the year deductibles will be asked to make a down payment prior to being seen. New patients will be asked to make a payment of $140.00 prior to being seen; established patients will be asked to make a payment of $90.00 prior to being seen. If labs are performed you may receive a bill from an outside lab. Once seen and services are rendered, the balance of payment due for that date of service is expected to be paid prior to leaving the office.

Credit Card Authorization/Payments: In recognition of the impact of the Affordable Care Act, we are requesting a separate signed authorization to hold your credit card data via a random alphanumeric token on a secure gateway server in order to charge any outstanding balance over 30 days old.

Copays and deductibles: All co-pays, deductibles and Co-insurances should be paid at the time of service, if payment is not received you will incur a fee of $5.00. Payment of co-pays & deductibles is part of your contract with your insurance company. Some insurance policies have a deductible that starts over at the beginning of every year, including Medicare. If your deductible has not been met, you will be expected to pay towards the amount at the time of service.

Non-Covered services: Please be aware that some of the services you receive may not be covered or considered medically necessary by Medicare or other insurance carriers. Unless prior arrangements are made with our billing department, these services should be paid at the time of service. If prior arrangements are made, you will be notified by a billing statement if your insurance company did not cover a service provided.

Authorization numbers/Referrals: When requesting an authorization or referral, you must give the office 5-7 business days to process the request. Failure to do so, may result in you having to reschedule your appointment. Your insurance company has established the guidelines by which your care must be rendered. Most insurance carriers take 5-7 days to process authorization/referral requests. Your insurance company has made it your responsibility to know your benefits coverage. While we will try to help you understand your benefits, patients are responsible for knowing if an authorization number or referral is needed. You must also make sure one is obtained when services are performed. If you fail to do so, the balance for the service will be your responsibility.

Collections: If your balance remains unpaid after 90 days, your account may be referred to an external collection agency. When your account is sent out, there may be a fee of 25% of your balance. If you have a balance in collections, you will be required to pay your collection balance before being seen by the doctor. The practice reserves the right to determine if they will continue serving as your primary care provider.

Bounced/Returned checks: There will be a $25 charge for any bounced checks.

Missed appointments: There may be a $35 charge for missed appointments.

Appointments Cancelled without a 24-hour notice: Please be courteous, other patients may need your appointment time. Canceling your appointment without giving the office enough notice may result in a $20.00 charge.

Copy of records: There may be a fee assessed for copying of records requested for personal use or other providers. Record copying fees are charged in accordance with Michigan legal recommendations.

Attending Physician Statements (APS): For completion of attending physician statements, there may be a charge of $95 (payable by you or your insurance carrier).

We accept the following for payment: Cash, Check, Money Order, Visa, Mastercard, Discover and American Express.

Thank you for understanding our financial policy. Please let us know if you have any questions.

_____ _____

Signature of patient or responsible party Date

Patient name

_____ _____

Print patient or responsible party Patient name Date of birth

The Patient-Doctor Partnership

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, *your doctor*, and you, *my patient,* work together. This concept is called the Patient Centered Medical Home.

Patient Responsibilities:

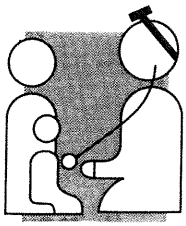
- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your doctor about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor *first* with all problems, unless it is a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans

Doctor Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to my patients' feelings and questions; help them make decisions about their care
- Keep treatments, discussions and records private
- Provide 24 hour access to medical care and same day appointments whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Give my patients clear directions about medicines and other treatments
- Send my patients to trusted experts, if needed
- End every visit with clear instructions about expectations, treatment goals and future plans

Print Name_____ Sign Name_____

Provider Signature_____ Date_____



Northville
Family
Medical
Center
Michael Wayne, D.O.
Board Certified

Pediatric Health Assessment

Name: _____ Birthdate: ____/____/____

Birthplace: _____ In U.S.A. _____ Years _____ Months

SECTION I: IMMUNIZATIONS

Vaccine Type — *Please specify the vaccine in the space provided.*

A. **DTP/DT/TP**
D = Diphtheria
T = Tetanus
P = Pertussis

1. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
2. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
3. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
4. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
5. ☐ Yes ☐ No _____ Month/Day/Year____/____/____

B. **Oral Polio**

1. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
2. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
3. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
4. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
5. ☐ Yes ☐ No _____ Month/Day/Year____/____/____

C. **TB Skin Test**

1. ☐ Yes ☐ No ☐ Negative ☐ Positive Month/Day/Year____/____/____

Treatment: _____

D. **Hepatitis B**

1. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
2. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
3. ☐ Yes ☐ No _____ Month/Day/Year____/____/____

E. **Chicken Pox**

1. ☐ Yes ☐ No _____ Month/Day/Year____/____/____

F. **Measles/Mumps/ Rubella**

1. ☐ Yes ☐ No _____ Month/Day/Year____/____/____
2. ☐ Yes ☐ No _____ Month/Day/Year____/____/____

F. **Other Immunizations**
(Please List)

_____
_____
_____
_____

SECTION II: HEALTH HISTORY

Has your child had any of the problems listed below?

☐ Yes ☐ No Hay Fever, Asthma, or Wheezing

☐ Yes ☐ No Convulsions/Seizures

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Liver Disease or Hepatitis

☐ Yes ☐ No Asthma

☐ Yes ☐ No Lung Problems

☐ Yes ☐ No Stomach or Other Gastrointestinal Problems

☐ Yes ☐ No Anemia or other Blood Problems

☐ Yes ☐ No Skin Problems

☐ Yes ☐ No Does your child wear eyeglasses?

☐ Yes ☐ No Trouble with passing urine or bowel movements

☐ Yes ☐ No Frequent colds, sore throats and earaches (4 or more per year)

☐ Yes ☐ No Any previous hospitalizations?

☐ Yes ☐ No Eczema or frequent skin rashes

☐ Yes ☐ No Heart trouble or murmurs

☐ Yes ☐ No Shortness of Breath

☐ Yes ☐ No Speech Problems

☐ Yes ☐ No Heart Problems

☐ Yes ☐ No Kidney Problems

☐ Yes ☐ No Headaches/Migraines

☐ Yes ☐ No Hay fever/Allergies

☐ Yes ☐ No Dental Problems

List any previous surgeries: _____

_____

_____

☐ Yes Does child take medications, vitamins or herbal supplements on a regular basis?
☐ No

If yes, list medications: _____

Reason for medication: _____

☐ Yes Does your child have any allergies?
☐ No

If yes, list the allergies and type of reaction your child experienced (medications, foods or other environmental products):

1. _____
2. _____
3. _____
4. _____

☐ Yes Has your daughter started her menses?
☐ No

If yes, at what age was her first menses? _____

Is your daughter menstruating now? _____

SECTION III: SOCIAL HISTORY

☐ Yes Does your child have any siblings? _____Brothers _____Sisters
☐ No

☐ Yes Are there any pets in the home?
☐ No If yes, what type? _____

☐ Yes Does anybody use tobacco in the home?
☐ No

☐ Yes Does your child attend school?
☐ No

What grade is your child in school? _____

☐ Yes Does your child participate in any extracurricular school activities or organized sports?
☐ No

If yes, list the activities or sports: _____

_____

How old is your home? _____

Does the house have _____ city water or _____ well water?

Does the house have _____ carpets or _____ hardwood floors?

SECTION IV: FAMILY HISTORY

Father's Age:_____ Previous medical history of father (Place information below).

1. _____
2. _____
3. _____
4. _____

Mother's Age:_____ Previous medical history of mother.

1. _____
2. _____
3. _____
4. _____

Have any of your relatives been diagnosed with the following conditions:

- ☐ Cancer
- ☐ Gastrointestinal Problems
- ☐ Multiple Sclerosis or other neurological problems

Do you have any other information about your child that you think may be important, but you have not addressed within this form? ☐ Yes ☐ No