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

NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for purpose of treatment, payment or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. You may want a friend or family member to discuss care with a physicians, or staff member, take messages, and pick up prescriptions or other medically related communications.

- Please indicate if there is a friend or family member to whom we are allowed to release medical information to:

Name: _____ Phone: _____

You may also identify a friend or family member to whom we are specifically restricted from releasing medical information.

- Please indicate if you want medical information restricted from:

Name: _____ Phone: _____

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Resources. We will not retaliate against you for filing a complaint.

For more information, please contact us at: (248)348-8700

This notice is effective:

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

_____ Date: _____

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

Adult Health History

Patient Last Name:_____ First Name:_____

Birthdate: _____ Age:_____ Sex: M F Marital Status: _____

History Questionnaire Completed by: Patient Spouse (Name)_____

Parent (Name) _____ Other (Name)_____

SECTION I: IMMUNIZATIONS / TB SKIN TESTING

Have you received immunizations for the following?

Tetanus/Diphtheria: Yes_____ No_____ Year_____

Polio: Yes_____ No_____ Year_____

Hepatitis B: Yes_____ No_____ Year_____

Measles/Mumps/ Rubella: Yes_____ No_____ Year_____

Flu Vaccine: Yes_____ No_____ Year_____

Chicken Pox: Yes_____ No_____ Year_____

Pneumonia Vaccine: Yes_____ No_____ Year_____

TB Skin Test?_____Positive or Negative?_____ When?_____

Have you traveled outside of the U.S. in the last two years?____Where?_____

SECTION II: PAST MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following? Circle yes or no

Yes	No	Anemia	Yes	No	High Blood Pressure
Yes	No	Allergies	Yes	No	Kidney Disease
Yes	No	Arthritis	Yes	No	Meningitis
Yes	No	Asthma	Yes	No	Measles
Yes	No	Bleeding Tendencies	Yes	No	Mumps
Yes	No	Blood Clots	Yes	No	Neurological Problems
Yes	No	Bronchitis	Yes	No	Pertussis (Whooping Cough)
Yes	No	Cancer	Yes	No	Pneumonia
Yes	No	Cataracts	Yes	No	Polio
Yes	No	Chicken Pox	Yes	No	Psychiatric Problems
Yes	No	Diabetes / Sugar	Yes	No	Prostate Problems
Yes	No	Diphtheria	Yes	No	Rheumatic Fever
Yes	No	Emphysema	Yes	No	Rubella
Yes	No	Glaucoma	Yes	No	Scarlet Fever
Yes	No	Gout	Yes	No	Seizure Disorder
Yes	No	Hay Fever	Yes	No	Skin Problems (Acne)
Yes	No	Heart Attack	Yes	No	Stomach Problems / Ulcers
Yes	No	Heart Disease	Yes	No	Stroke / CVA
Yes	No	Hearing Problems	Yes	No	Thyroid Problems
Yes	No	Hepatitis / Liver Disease	Yes	No	Tuberculosis

Patient Name: _____

SECTION VI: SOCIAL HISTORY AND HABITS

Alcoholic Beverages (including beer and wine): How many drinks per day? _____

Do you use street drugs (including cocaine, heroin or marijuana)? ___Yes ___No Substance _____

Do you use any of the following:

_____Cigarettes	_____ Packs Per Day	_____ How Many Years?
_____Pipe	_____ Hours Per Day	_____ How Many Years?
_____Cigars	_____ Number Per Day	_____ How Many Years?
_____Chewing Tobacco		
_____Snuff		

Have you quit smoking? ___Yes ___No When?_____

SECTION VII: FAMILY MEDICAL HISTORY

Indicate the medical history of your family members. Check YES or NO and indicate relative: mother, father, brother, sister, grandparents

Yes	No	Anemia	Yes	No	Lung Disease
Yes	No	Blood Clots	Yes	No	Psychiatric Disorder
Yes	No	Cancer	Yes	No	Sickle Cell
Yes	No	Diabetes	Yes	No	Stroke
Yes	No	Heart Problems	Yes	No	Thyroid Problems
Yes	No	High Blood Pressure	Yes	No	Tuberculosis

Other: _____

SECTION VIII: HISTORY OF PRESENT ILLNESS / CHIEF COMPLAINT

Yes	No	Abdominal Pain	Yes	No	Eyesight Changes
Yes	No	Back Pain	Yes	No	Fever / Chills
Yes	No	Blood in Nose	Yes	No	Hearing Problems
Yes	No	Blood in Stool / Bowel Problems	Yes	No	Heart Beating Fast
Yes	No	Blood in Urine	Yes	No	Loss of Consciousness
Yes	No	Breast Mass / Discharge	Yes	No	Nausea or Vomiting
Yes	No	Chest Pain	Yes	No	Shortness of Breath
Yes	No	Cough	Yes	No	Vaginal Discharge, Burning, Itch
Yes	No	Dizziness	Yes	No	Wheezing

Patient Name: _____

Have you ever had any of these sexually transmitted diseases?

Yes	No	Chlamydia	Yes	No	Syphilis
Yes	No	Gonorrhea	Yes	No	Venereal Warts
Yes	No	Herpes	Yes	No	AIDS
Yes	No	HIV Positive			

SECTION III: PAST SURGICAL HISTORY

List all surgeries you have had since birth.

Surgery _____ Year_____

Surgery _____ Year_____

Surgery _____ Year_____

Surgery _____ Year_____

SECTION IV: CURRENT MEDICATIONS

Include dosage of:
Vitamins, Aspirin, Birth Control Pills, Over-the-Counter Meds, Health Food Store Meds, Oxygen

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SECTION V: ALLERGIES

List any medication, food or environmental allergies.

_____ _____

_____ _____

_____ _____

Explain the type of reaction you experienced and any treatment you received.

_____

_____

Patient Name: _____

Do you have any of the following?

Yes No Urinary Frequency / Urgency Yes No Urinary Discomfort

Yes No Weight Change Amount of Weight Change?_____(Up or Down)

Explain any "Yes" Answers (include the date it occurred)

_____

_____

SECTION IX: FEMALES

Menstrual Cycle:

Age at first period?_____ Age at menopause?_____ Are/were your periods regular?_____Number of days between periods? ___

Number of days of menstrual flow? _____Describe your menstrual flow: Heavy____ Average____ Light___Painful____

Menopause:

Any bleeding or spotting since menopause? Y N Describe_____

Ever taken hormones, shots or pills? Y N Describe_____

Past History:

Had pain or discomfort with intercourse? Y N Describe_____

Had any bleeding or spotting after sex? Y N Describe_____

Had a urinary tract or bladder infection? Y N Describe_____

Had a vaginal infection such as yeast? Y N Gardnerella? Y N Trichomonas? Y N

Had an abnormal Pap smear? Y N What was done about your abnormal pap? Colposcopy_____(date)

Freezing _____(date)

Laser _____(date)

Birth Control:

Current method of birth control? Birth Control Pills (name)_____Diaphragm_____

Intrauterine Device (IUD) _____Other_____

List all pregnancies you have had and their outcome.

Year	Length of Pregnancy	Vaginal or Caesarean Delivery	Miscarriage or Abortion	Complications

ıtient Signature: _____ **Date:** _____