Neighborhood Primary Care

PATIENT INFORMATION SHEET

PATIENT INFORMATION (Please Print):

Name (Last): _____ (First): _____ (MI): _____

Date of Birth: ____-____-_____ Gender: ☐ Male ☐ Female ☐ Neutral

If Under 18 Parents Name: _____ Date of Birth: ____-____-_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: ☐ Home ☐ Cell ☐ Work _____

Secondary Phone #: ☐ Home ☐ Cell ☐ Work _____

Email Address: _____

Would you like access to the patient portal? ☐ yes ☐ no

Preferred Pharmacy: _____ City Located: _____

Social Security Number: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Decline ☐ White ☐ American Indian ☐ Asian ☐ African American ☐ Other _____:

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

May we leave messages on your answering machine or voicemail? ☐ yes ☐ no

May we share your protected health information with a family member? ☐ yes ☐ no

Please list names: _____

Do you have an advance Directive? ☐ yes ☐ no (To learn more go to Michigan.gov)

Emergency Contact: _____ Relationship: _____

Preferred Emergency Contact #: _____ Secondary #: _____

_____ Today's Date: _____

Patient/Parent/Guardian's Signature

Neighborhood Primary Care

1261 S. Lapeer Road,
Lake Orion, Michigan 48360
Phone: 248-690-9181

CONSENT TO TREATMENT AND RELEASE OF INFORMATION

Consent to Treatment: I consent to medical, diagnostic, therapeutic, and minor surgical procedures and treatment by the physicians and staff of Neighborhood Primary Care, PLLC. (NPC) I understand the risks of the medical treatment and procedures, and no guarantees or promises have been made concerning the outcome of such procedures and treatment. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am authorized to make decisions, including my right to refuse medical and surgical procedures.

☐ **I have** an Advance Directive (living will, health care surrogate declaration, durable power of attorney) and request that it govern my care if I am unable to make decisions. I understand that it is my responsibility to provide NPC with a copy of my Advance Directive.

☐ **I do not have** an Advance Directive.

I understand that if any agent or employee of NPC sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or RPR; and I consent to such tests.

Release of Protected Health Information ("PHI"): I authorize the release of PHI such as my medical records and information about my appointments, tests, treatments, and/or other information pertinent to my healthcare or payment for my healthcare provided at PTMC to:

Please write in this area anyone you would like to give permission to see your or your child's Medical Records.

1. Any insurance carrier, workman's compensation or agency (social welfare, governm responsible for all or any part of PTMC's charges and/or professional fees.
2. Any physician or health care facility as may be needed for any treatment and care.
3. Any Peer Review Organization responsible for reviewing medical care.
4. An employer or any other entity authorized to approve or disapprove disability bene
5. The following individuals / organizations:

Name:_____ Relationship:_____ Date of Birth: _____

Address:_____

Name:_____ Relationship:_____ Date of Birth:_____

Address: _____

The release of PHI to the individuals / organizations listed above will not include the following information unless the appropriate box is checked:

- ☐ Any records of treatment for drug and/or alcohol dependency or abuse.
- ☐ Any record of mental health treatment, psychological services, social services, including communications made to a social worker or psychologist.
- ☐ Any record of testing, care, treatment or research pertaining to HIV, AIDS or other communicable diseases.

Confidential Communications: You may ask NPC to contact you or your designee at alternative locations. Please print the address where you would like NPC to send your correspondence if other than your home.

_____

Do you want NPC to remind you about your appointments by sending postcards? YES ___ NO ___

If you do not want NPC to call your home telephone number, please list the telephone number where you want to receive calls about your appointments, lab and x-ray results, and other PHI:

May NPC leave messages containing PHI on your home or the alternative telephone answering system?
YES ___ NO ___

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Procurement of Information: I authorize NPC to obtain my PHI and any medical records from other physicians, hospitals or health care facilities as needed for my medical care or the medical care of the person for whom I am authorized to sign.

Notice of Privacy Practices. I have reviewed NPC's Notice of Privacy Practices.

The consents and authorizations given above may be revoked at any time except to the extent that action has already been taken in reliance thereon. If not previously revoked, the consents given above shall expire on the date which is ten (10) years from the date of your last visit to NPC.

FINANCIAL RESPONSIBILITY

Assignment of Benefits: I hereby assign to NPC all rights to insurance payment for professional services provided by it. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. This assignment will remain in effect until it is revoked by me or the person for whom I am authorized to sign. A photocopy of this assignment is to be considered as valid as the original.

Guarantee of Payment: I agree to be responsible to NPC for charges resulting from services rendered that are not covered by insurance or other third party payment. I agree all bills are due in full at the time of service. Should I fail to honor this agreement, I agree to pay any collection cost and / or attorney fees resulting from the collection of my accounts.

Certification: I certify that I have read or had this form read and / or explained to me, that I fully understand the consents and authorizations given above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the patient or I am authorized by the patient to consent. All statements I do not approve of were stricken before I signed this form.

AKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Patient Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of the same. *You may refuse to sign this acknowledgement form.*

By signing this form I confirm that I have received a copy of the office Notice of Privacy Practices.

Print Name	Signature of Patient, Parent or Guardian	Date

If Patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reason:

- ☐ Minor
- ☐ Disoriented
- ☐ Incompetent
- ☐ Medically Unstable

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T: 248-690-9181 F: 248-690-9675

Insurance **copayments will be collected on date of service**. If you are unable to pay your copayment today or any previous balances, you may need to reschedule your appointment. Patients without insurance must pay in advance for appointment. For your convenience, our office accepts personal checks Visa, Mastercard, American Express, Discover and cash.

Please remember your **insurance policy is between you and your insurance company** and not the insurance company and your doctor. We will try to assist you, when possible, to understand your insurance, however, due to the variety of policies and constant changes, it is difficult for our office to interpret each individual policy. It is your responsibility to know the special terms, deductibles, and/or co-payments of your insurance coverage. Failure to notify us may result in non-covered expenses which will be your responsibility.

I understand the billing procedures associated with this office and understand that additional charges may be incurred if I fail to comply. I understand that my insurance may pay less than expected and that I am responsible for non-covered services on my behalf or my dependents. I further authorized neighborhood primary care be allowed to release information regarding my treatment to appropriate insurance company in order to receive payment.

I Understand and acknowledge that there will be a charge of $35.00 for all appointments not rescheduled or canceled at least **24 hours in advance** of a scheduled appointment with Neighborhood Primary Care.

I acknowledge that I have read and/or received a copy of the Neighborhood Primary Care billing policies. I agree to the terms listed within.

Printed Name: _____ **Date** _____

Signature: _____ _____

Relationship to Patient: **Self** **Parent** **Guardian** **Other:** _____

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APPOINTMENTS

Due to many changes in insurance coverage, it will be necessary to present your insurance card and picture ID at each appointment. Please note that due to thousands of insurance plans, you are responsible to understand your specific coverage.

Please arrive at or before your scheduled appointment time or 15 minutes early if you are a new patient and need to complete paperwork. If you are unable to keep your appointment, we need at least 24 hours' notice. If you do not show for you appointment you may be charged a $35 no show fee.

PRESCRIPTIONS AND REFERRALS

If you need a new prescription or refill for your current medication, please allow the office 48 hours to process your request. All prescription requests need to be verified by your physician before they are filled.

Please allow up to five business days for a referral and we will need the doctor's name spelling, office phone number, fax number and date of appointment along with why you are seeing a specialist.

MEDICAL RECORDS

We must have a signed authorization by you to release your records and please allow 15 business days to process. Based on the guidelines set forth by state law, there may be a fee depending on the size of your medical record.

PATIENT PORTAL

Neighborhood Primary Care utilizes a patient portal as a service to patients who wish to view parts of their medical records. Our portal uses encryptions so that only the authorized person with the correct user's name and password can see the record. It is important that you inform us of any email changes and you keep your information secure. Signing the agreement below, you understand the risks implemented by the portal.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

Please carefully review the attached notice of neighborhood primary care privacy policies and practices this notice describes how information may be used and disclosed and how you can get access to this information.

I acknowledge that I read and or received a copy of the Neighborhood Primary Care notice of privacy and practices and other office policies I agree to the terms listed within.

Printed Name: _____ **Date:** _____

Signature: _____

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PATIENT – PHYSICIAN PARTNERSHIP AGREEMENT

Thank you for choosing our medical practice for your home base for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuous and personal medical care. For this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

PHYSICIAN RESPONSIBILITIES

- Listen to you, as your healthcare matters
- Provide information for chronic conditions or prevention programs
- Provide flexible and expanded office hours, schedule appointments within a reasonable time, and see patients as closely to scheduled appointment time as reasonably possible
- Provide telephone availability to Physician for urgent communications 24 hours per day, 7 days per week
- Coordinate and integrate care provided by my practice team and other clinicians and health care institutions effectively to avoid duplication, delay, and error
- Communicate test and treatment results promptly and correctly
- Provide information, recommendations and advice regarding preventive care, maintaining wellness, self-management direction and counseling
- Provide reminders for scheduled appointments, follow-up and preventive care
- Maintain clinical information that allows us to participate in the development and maintenance of standardized patient registries

PATIENT RESPONSIBILITIES

- Communicate openly
- Participate in creating treatment plans, follow agreed-upon treatment plans, and provide feedback on treatment plans
- Respect the time of others by being on time for appointments and procedures
- Schedule and attend follow-up appointments
- Involve yourself in all your health care professionals' recommendations with respect to maintenance or improvement of your health and wellness
- Participate in action planning and goal setting with respect to maintenance or improvement of your health and wellness
- Participate in developing and maintaining a comprehensive health record by authorizing delivery and circulation of clinical information to and from members of your healthcare team

PLEASE READ THIS MEMO OF UNDERSTANDING AND SIGN YOUR NAME BELOW

Patient Signature _____ Date _____ Physician Signature _____

Neighborhood
Primary Care

MINOR CHILDREN AND WARDS

Information concerning minor children and wards:

Name: _____ Relationship:_____ Date of Birth:_____

Address:_____

Name: _____ Relationship:_____ Date of Birth:_____

Address: _____

I authorize NPC to provide my minor children and wards with any required medical, diagnostic, therapeutic, and minor surgical procedures and treatment, as may in their professional judgment be necessary or beneficial for their health in my absence.

I authorize the person(s) listed below to accompany my minor children or wards and be present during medical examinations, treatment or procedures:

Name: _____ Relationship:_____ Date of Birth:_____

Address:_____

Name: _____ Relationship:_____ Date of Birth:_____

Address: _____

_____ _____ DOB:_____

Print Name Signature of Parent/Gurdian

Relationship to Patient: _____ Date: _____

_____ _____

Signature of Witness Date