western michigan PEDIATRICS

ADULT REGISTRATION FORM

Patient Information **Date**_____

Last_____First _____ MI __ DOB_____ Preferred Name_____ Sex at birth: M F

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: American Indian / Asian / Black / Hawaiian / White Preferred Language:

Address _____ Primary Phone _____ Is this a cell phone? Yes No

Street City State zip

email address _____ Employed _____ Not Employed _____ Full time student _____

If employed, employer name _____ Employer phone _____

Appointment Reminder Preferred Contact Method Text to Cell or Phone Call Phone number _____ Whom does phone belong to?

Insurance Information

Primary Insurance

Name of Insurance company _____ Policy Holders Name _____

Policy holders date of birth _____ ID # _____ Grp # _____

Relationship to patient _____ Lives with patient: YES ** If not, please complete policy holders info below

Address _____

Cell Phone (_____) _____ email _____

Employer _____ Occupation _____ Work phone (___) _____

Secondary Insurance

Name of Insurance company _____ Policy Holders Name _____

Policy holders date of birth _____ ID # _____ Grp # _____

Relationship to patient _____ Lives with patient: YES ** If not, please complete policy holders info below

Address _____

Cell Phone (_____) _____ email _____

Employer _____ Occupation _____ Work phone (___) _____

OVER → →

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Emergency Contacts

Name_____ Relationship to patient_____ Phone number (___)_____

Name_____ Relationship to patient_____ Phone number (___)_____

I authorize payment of medical benefits by the insured directly to Western Michigan Pediatrics. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services within 30 days unless a payment plan is negotiated in advance. I authorize Western Michigan Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

_____ _____

Patient signature Date

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

_____ _____

Patient signature Date

Authorization for Specific Confidential Communications

Is it ok to leave a detailed message including medical information on your voicemail? Yes ____ No ____ List Phone #:_____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care/Treatment
- ☐ Billing Information
- ☐ Appointments
- ☐ Pick up PHI (such as prescriptions, billing statements, labs, etc.)
- ☐ Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, origin of information, etc.)

_____

_____

I specifically consent to the disclosure as indicated above that may contain the following information:

- ☐ Alcohol/Drug/Substance Abuse information _____ (initials)
- ☐ HIV test results or diagnosis of AIDS and AID's related conditions _____ (initials)
- ☐ Mental Health information _____ (initials)
- ☐ Pregnancy information _____ (initials)
- ☐ Sexually transmitted diseases (STD) information _____ (initials)

_____

This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Western Michigan Pediatrics, 721 Kenmoor Ave SE, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient signature Date