Patient Information Sheet – Must bring Photo ID and Insurance Card to Visit

Responsible Party Information (Must be over 18 years and/or Legal Guardian)

Please Print Clearly

☐ Patient ☐ Guardian

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐Divorced

Emergency Contact: _____ Date of Birth: _____ Phone: _____

Pharmacy Name: _____ City Location: _____

Dependent / Patient Information (Children)

First Name	Middle Initial	Last Name	Sex M / F	Birth Date	Relationship to Responsible Party

Insurance Holders Name: _____ **Date of Birth:** _____

Consent for 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 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 a right to make decisions concerning my healthcare or the healthcare of the person whom I am authorized to make decisions, including my right to refuse medical and surgical procedures.

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.

By signing this form below, I agree to the above statements and have reviewed the notice of privacy practice.

_____ _____

Signature of Patient / Legal Guardian **Date**

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 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 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 were stricken before I signed this form.

_____ _____

Signature of Patient or Legal Guardian **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that healthcare providers give patients a copy of the office Notice of Patient Privacy Practices and make a good faith effort to obtain an acknowledgement of the 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 Patient Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian **Date**

For Office Use Only:

☐ Patient refused to Sign ☐ Emergency Situation ☐ Unable to Communicate with Patient

☐ Other: _____

Acknowledged by: _____ Date:_____

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 provided at NPC to:

1. Any insurance carrier, workman's compensation or agency (social welfare, governmental) responsible for all or any part of NPC'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 benefits.
5. The following individuals / organizations:

The release of PHI to the individuals / organization 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.)
(Any individual or facility who you wish to have access to your medical records, please list below)

Name: _____ Relationship: _____ Date of Birth:_____

Address: _____

Name: _____ Relationship: _____ Date of Birth:_____

Address: _____

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 or texts? ☐ YES ☐ NO

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

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

_____ _____

Signature of Patient or Guardian **Date**

Minor Children and Wards

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(s) for whom I am authorized to sign.

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

These 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 (10) years from the date of your last visit to NPC.

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 judgement 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: _____

_____ _____

Signature of Patient or Guardian **Date**

Neighborhood Primary Care

1261 S. Lapeer Rd, Suite 202
Lake Orion, MI 48360
T: 248-690-9181 F: 248-690-9675

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