Harbour Towne Health PLLC

131 W. Seaway Drive, Suite 200
Muskegon, MI 49444
Phone: 231.375.8065
Family Medicine Fax: 231.375.8063
Psychiatry/Counseling Fax: 231.375.8076

REGISTRATION FORM

(Please Print)

Today's date:					**Provider Preference**: ❑ Male ❑ Female ❑ Either		
PATIENT INFORMATION							
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Primary phone no.: ( )		
City:	State:	ZIP Code:			Cell phone no.: ( )		
Occupation of patient:	Employer/School Name of Patient:				Employer phone no.: ( )		
Email:							

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for insurance coverage:	Birth date: / /	Address (if different):		Primary phone no.: ( )	
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Please indicate primary insurance ❑ Aetna ❑ BCBS ❑ Humana ❑ Medicaid of MI ❑ Medicare of MI ❑ Meridian Medicaid ❑ Molina ❑ Priority Health ❑ Priority Health Medicare ❑Wellcare ❑ Other (specify) _____					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Primary phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize HARBOUR TOWNE HEALTH or insurance company to release any information required to process my claims.

X _____ _____

Patient/Guardian signature *Date*

Harbour Towne Health PLLC

POLICIES

Please review, then sign and date at the bottom to acknowledge your understanding of the clinic policies of Harbour Towne Health.

- Co-pays are expected **at the time of service. If you are unable to make payment at the time of service, your appointment will be rescheduled.** We will submit claims to your insurance company as a courtesy; however, please know that you are responsible for ALL fees if your insurance does not cover our services for any reason. Insurance companies list coverage for psychiatrists' services under "Outpatient Mental Health." Please familiarize yourself with your policy benefits by calling the number on the back of your insurance card.
- Failure to pay on outstanding balances may result in discharge from our clinic.
- Keep and be on time for your appointments. This is your responsibility. **If you are more than 10 minutes late, you will be asked to reschedule. If you miss an appointment and do not call to cancel 24 hours prior, we may charge you a $50 cancellation fee.** This time has been reserved exclusively for you, and it is important to keep your scheduled appointment; this is not a penalty. We cannot bill your insurance for this fee. This payment must be made by you before you can be seen for another appointment.
- **Two consecutive no-shows or three no-shows within a rolling calendar year may result in discharge from our clinic.**
- Non-compliance with treatment may result in discharge from our clinic.
- Please be courteous to staff and fellow patients. Hostility will result in discharge.
- **MEDICATION REFILL REQUESTS REQUIRE 2 FULL BUSINESS DAYS TO PROCESS.** Sometimes an appointment is required for medication changes and/or refills.
- If your medication is not covered and your insurance requires a prior authorization, formulary exemption, tier or quantity exemption, please have your pharmacy fax us a request with your prescription plan information. NOTE: After we submit the necessary paperwork, the processing time will depend upon your insurance company.
- Please SILENCE YOUR CELL PHONE inside our clinic.
- This is an outpatient facility; there is no emergency/afterhours contact number. If you have an emergency, please call 911 or proceed to the nearest emergency room.

Family Medicine office hours are Monday, Tuesday & Thursday 8:30am-4:30pm and Wednesday & Friday 8:30am-2:30pm by appointment only.
Psychiatry office hours are Monday – Wednesday 8:00am-5:00pm, Thursday 8:00am-4:00pm and Friday 8:00-12:00pm. Counseling office hours are Monday-Thursday 8:00am-4:30pm and Friday 8:00am-3:30pm.
I acknowledge that I have read and understand the policies for Harbour Towne Health.

X _____

(Patient/Guardian Signature) (Printed Name)

Date: _____

Harbour Towne Health PLLC

CONSENT TO TREAT

All references to "patient", "me" and "my" in this document means:

_____ _____

Name of patient Date of Birth

I have the legal right to consent to medical treatment because I am the patient, or I am the parent/guardian of the patient.

PLEASE INITIAL TO THE RIGHT OF EACH STATEMENT ACKNOWLEDGING YOUR UNDERSTANDING:

I acknowledge that I am voluntarily consenting to health assessment and/or treatment services. I have the following rights regarding services and may discuss these at any time with my health professional:

1. I can discuss any intervention being suggested as well as any questions I have concerning the course, purpose and direction of treatment (i.e. how the treatment will work).
2. I have the option to explore any other possible treatments or alternatives to psychotherapy.
3. I have the opportunity to discuss any possible risks, discomforts or side effects as well as any benefits that may occur in the course of treatment.
4. I have the right to withdraw from treatment at any time. (It is preferable to discuss this with my provider.)
5. If video or audio recording of sessions is to occur, this would require additional consent, for which a form will be provided. I have the right to refuse such additional consent.
6. Provider will talk about the limitations of privileged communications and confidentiality. Any questions I have will be answered.
7. I understand that there are no guarantees that can be promised regarding the outcome of treatment. I will be informed of what outcomes are possible.
8. I understand that in the event of an emergency, contact will be made with the appropriate parties on my behalf to protect myself or others.

Initial_____

I understand by signing this form, I am giving permission to the doctors, physician assistants, nurse practitioners, counselors and other health care providers in this medical office to provide treatment as long as a provider/patient relationship exists, or until I withdraw my consent.

Initial _____

Harbour Towne Health PLLC

We share medical records electronically and in paper form with other health care providers to allow and promote continuity of care among providers. If you visit another provider in Harbour Towne Health's integrated group who also participate in electronic medical system, they may have to access to your medical records.

Initial _____

As a service to our patients, Harbour Towne Health PLLC provides courtesy appointment reminder calls/text that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls/text at the cell/home phone number you have provided to us.

Initial _____

I authorize Harbour Towne Health PLLC to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a provider/patient relationship exists, or until I withdraw my consent.

Initial _____

IN GRANTING PERMISSION FOR TREATMENT OF MY MINOR CHILD I UNDERSTAND ADDITIONAL PROVISIONS APPLY:

1. Under state law if a mental health professional knows or has a reason to believe that my child has been or is being physically abused, sexually abused, or neglected, this information must be reported to Child Protective Services. All information concerning danger to a child will be reported.
2. I understand that the specific content of sessions between my child and his/her provider is confidential, and that my child may request that information about his/her treatment not be shared with me. General reports of my child's progress may be provided to me under his/her agreement.

Initial _____

I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

_____ _____
Print Patient/Guardian's Name Relationship

X _____ _____
Signature of Patient/Guardian Date

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FINANCIAL POLICY

Thank you for choosing Harbour Towne Health PLLC. We are committed to providing you with quality and affordable healthcare. Just as we want you to be knowledgeable about your health care, we also want you to understand the financial policy of Harbour Towne Health PLLC. Please understand that payment of your bill is considered a part of your treatment. The following is our Financial Policy, which we require to be read and sign.

Full payment of your copayment, deductible, and non-covered services are due at the time of service. We accept cash, check and most credit cards (Visa, MasterCard, Discover, American Express and Debit Cards)

Patient/Guarantor Demographic Information

To appropriately bill your insurance company, we will request the following information: current insurance card, current address, and date of birth of the subscriber (it is your responsibility to keep your information up to date). If you choose not to provide us with your information, you will be considered self-pay and payment for your services will be expected at the time of your service.

Your driver's license will also be requested per The Red Flag Rule. For information regarding the Red Flag Rules, please refer to the Federal Registry at https://www.gpo.gov/fdsys/pkg/FR-2014-05-29/pdf/2014-12358.pdf
If we are unable to locate you to collect debt, your account will be placed with an outside collection agency.

Divorce/Minor Children

Who is responsible for payment of services provided to minor children when the parents are divorced?
According to the law, both parents are legally responsible.
Harbour Towne Health will not become engaged in a dispute for payment of these services, the parent who consents for treatment will be held legally responsible for payment of any services provided to the minor child.

Insurance

Harbour Towne Health PLLC participates with most insurance plans including Medicare, BCBS, BCN, ASR and Priority Health. Knowing your insurance benefits is a patient's responsibility. Please contact your insurance company with any questions that you may have regarding coverage.

Non-participating/Out of Network Insurances

If Harbour Towne Health PLLC does not participate with your insurance, you are responsible for full payment at the time of service for all services rendered. If you have out-of-network benefits and your insurances sends a reimbursement check to you, it is your responsibility to sign it over to Harbour Towne Health PLLC, immediately. Failure to do so will lead to sending your account to collections.

Deductibles/Copayments & Non-covered Services

All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Missed/Cancelled Appointments

There will be a $25.00 charge for 15-minute appointments when you no-show or do not provide 24 hours' notice for a cancellation. If you have a 30-minute appointment, the charge will be $50.00.

Examples of 15-minute appointments: Sick Visit, Follow-up, Well-Child Visits.
Examples of 30-minute appointments: Annual Physical Exam, New Patient Appointments, Procedures.

Three no-shows or late cancellations in a one-year period could result in dismissal from the practice. We understand that life happens, and we are generally understanding of some circumstances. Please respect our provider's time and give adequate time for us to fill your appointment slot if you are unable to make it.
If you are more than 10 minutes late for your appointment, we may request that you reschedule.

Refunds

If you have a patient credit on your account, it will be refunded to you within 90 days of the credit becoming due to you. If you are aware that you have a credit and wish to keep it on your account for future out of pocket expenses, please contact our office.

Patient Balances After Insurance

After your insurance company responds to your claim with either a payment or denial, the self-pay balance that will be billed is due upon receipt of your statement. All patient balances are due in full within 30 days after you receive your first statement.

Returned Checks

If we receive your check back from our bank indicating non-sufficient funds or closed account, there will be a charge of $30.00 to you to cover our bank fees. If you have 2 non-sufficient funds checks, you will be asked to pay with cash or with credit card.

Bad Debt Accounts

If after 60 days, you fail to satisfy payment on your account and do not contact our billing department to make arrangements for payment; your account may be sent to a debt collector agency to collect debt on our behalf. If your account is placed in an outside collection agency, you will be notified by certified letter that you have been discharged from the practice and have 30 days to find a new provider. We will only provide urgent care to you during this 30-day transition period. A copy of your medical records will be forwarded to a provider of y our choice once a medical records release form is signed by you and sent to us. Please allow 30 days for your records to reach your new provider.

Harbour Towne Health PLLC

Form Fees

Harbour Towne Health PLLC will charge a fee of $25.00 for forms that need to be filled out by the provider unless you are scheduling an office visit to complete the form. If you are dropping off, mailing, or faxing forms for completion, you will be expected to pay this fee at the time of pick up.
Exceptions: If you have a form that your insurance company is requesting your provider to fill out (Healthy Blue Living for Blue Care Network or Health by Choice for Priority Health), we will not charge for completing these forms. However, if you have not been seen in the office by one of our providers within six (6) months, you will be required to be seen prior to the form being filled out and forwarded to your insurance company. If you request a copy of your medical records for your own personal use, there will be a fee assessed. There is no fee if copies of your records are forwarded to another physician per your request.

I further understand that part of the financial policy includes policies relating to unpaid copayments, "no showed" and "late cancel" appointments. I understand that Harbour Towne Health PLLC expects full payment, within 30 days, from me on patient balances after my insurance is billed and responds to my claim. If I am self-pay (uninsured/no insurance), I understand that I am expected to pay my charges in full on the date the services are provided to me.

I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

X _____ _____

Signature of patient (parent/guardian if a minor) Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RECORDS

PATIENT NAME: _____ _____ _____
LAST FIRST MI

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

_____

DATE OF BIRTH _____ SSN# _____

I hereby authorize: _____ (Previous Provider/Facility Name)
_____ (Previous Provider Address)
_____

Previous Provider Phone: _____ **Fax:** _____ **to release information from my medical records to Harbour Towne Health PLLC for continuation of care.**

INFORMATION TO BE RELEASED: **DATES:**

- ☐ History and physical exam _____
- ☐ Progress notes _____
- ☐ Lab reports _____
- ☐ Imaging reports (X-rays,MRIs, CT) _____
- ☐ Other: _____ _____
  _____

I specifically authorize the release of medical information relating to:

- ☐ **Substance abuse (including alcohol/drug abuse)**
- ☐ **Medical health (including psychotherapy notes)**
- ☐ **HIV related information (AIDS related information)**

☐ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

This information may be disclosed and used by the following individual or organization:

Release to: HARBOUR TOWNE HEALTH PLLC
Address: 131 W SEAWAY DRIVE, SUITE 200, MUSKEGON, MI 49444

Fax: (231)375-8063 ☐ **Please fax records**

Phone: (231) 375-8065 ☐ **Please mail records**

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Medical Records Director and any information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose above. I understand that I am not required to sign this authorization, and that HARBOUR TOWNE HEALTH PLLC/ HARBOUR TOWNE HEALTH PROVIDER will not refuse me treatment if I refuse to sign. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it. If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition:

X _____ _____
Signature of Patient or Legal Representative Date

X _____ _____
Harbour Towne Health PLLC Office Staff Signature Date