Maternal-Fetal Medicine Associates, P.C.

PATIENT REGISTRATION FORM

1000 East Paris SE Suite 210 • Grand Rapids, MI 49546 • (616) 285-3310

PATIENT INFORMATION

Patient Legal Name: ______________________________
FIRST MIDDLE LAST

Street Address: ______________________________

City: ____________ State: ____________ Zip: ____________

Home Phone# ____________ Cell# ____________ Alternate# ____________

Email Address: ______________________________ NAME: ____________

Birthdate: ____________ Sex: ❑M ❑F Marital Status: ❑S ❑M ❑D ❑Sep

Social Security No: ____________ Drivers Lic.# ____________

Occupation: ______________________________ ❑ Full-time ❑ Part-time ❑ Not employed

Employer Name: ____________ Work Phone: ____________

Employer Address: ____________ City: ____________ Phone: ____________

Guarantor: ____________ Relationship: ____________

INSURANCE INFORMATION *Please write information about the patient insurance here.*

Primary Coverage

Insurance Company Name: ____________ Phone: ____________

Contract Number: ____________ Group Number: ____________

Employer Group Policy? ❑ Yes ❑ No Employer: ____________

Employer Address: ____________ Phone: ____________

Policyholder Name: ____________ Birthdate: ____________

SSN: ____________ Rel. to Patient: ❑ Self ❑ Spouse ❑ Parent/Guardian

Effective Date: ____________ Term Date: ____________

Medicaid Recipients: Caseworker Name: ____________ Phone# ____________

Secondary Coverage

Insurance Company Name: ____________ Phone: ____________

Contract Number: ____________ Group Number: ____________

Employer Group Policy? ❑ Yes ❑ No Employer: ____________

Employer Address: ____________ Phone: ____________

Policyholder Name: ____________ Birthdate: ____________

SSN: ____________ Rel. to Patient: ❑ Self ❑ Spouse ❑ Parent/Guardian

Effective Date: ____________ Term Date: ____________

REFERRAL INFORMATION *Who referred you to our office?* ❑ Doctor ❑ Ins. Co. ❑ Relative ❑ Yellow Pages ❑ Other: ____________

Name of Referring Physician: ______________________________

Complete Address: ______________________________

Office Phone Number: ______________________________

Do you have a Primary Care Physician? ❑ Yes ______________________________ ❑ No

EMERGENCY INFORMATION *Who can we notify in case of an emergency?*

Name: ______________________________ Phone Number: ____________________

Relationship: ______________________________

ALLERGY INFORMATION *Do you have any allergies?*

Latex: ❑ Yes ❑ No Medications: ❑ Yes ❑ No ______________________________

Other: ❑ Yes ❑ No ______________________________

FINANCIAL POLICY

We understand dealing with your insurance carrier can sometimes be complex and difficult; however, it is impossible for our office to be the mediator between the patient and the insurance company. Therefore, your insurance coverage must remain a contract between you, your employer and the insurance carrier. We will gladly discuss our fees in advance and answer questions relating to your insurance. All copays, deductibles, and co-insurance must be paid at the time of service. This may be an estimate of what you may owe. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing supervisor for assistance in the management of your account. A $20 rebill fee is added to all accounts considered to be past due.

PRIVACY NOTICE ACKNOWLEDGEMENT AND RELEASE OF INFORMATION

I acknowledge that I have received or have been offered the Notice of Privacy Practices for Maternal-Fetal Medicine Associates, P.C. ______________ Initial

I authorize Maternal-Fetal Medicine Associates, P.C. to discuss my medical information with: (ex: spouse, child family member or physician) (As Required By HIPAA)

Name: ______________________________ Relationship: ______________________________

MEDICAL REPORTS

As a courtesy to you and the physicians that care for your health needs, a report of your visit(s) will automatically be sent to the referring physician and/or your designated Primary Care physician unless you advise us otherwise.

ASSIGNMENT OF BENEFITS AND CREDIT TERMS

I, the undersigned, do assign directly to Maternal-Fetal Medicine Associates, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release any and all medical records to my insurance carrier or agent to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. A $20 rebill fee is added to all accounts considered to be past due.

______________________________ ______________________________

Patient/Guarantor Relationship to Patient Date

______________________________ ______________________________

Spouse/Significant Other Date

Understanding Your Health Record/Information

Each time you visit our office, a record of your visit is made. Typically, this record contains your signs and symptoms, examination and test results, diagnoses, treatment, medical records transferred from other physicians/ hospitals and a plan for future care or treatment. This information, often referred to as your medical record, serves as a basis for planning your care and treatment, a means to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For any other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Understanding what is in your record and how your health information is used helps you to ensure accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

We may change our policies any time. Prior to making any significant change in our policies, we will change our notice and post the new notice in the waiting area and examination rooms. You may also request a copy of our notice at any time. For more information about our privacy practices, you may contact the person(s) listed below.

Individual rights

In most cases, you have the right to look at or obtain a copy of your health information we use to make decisions about your care. However, this is only done with a physician or a physician's approval. If you request copies of your medical record, we charge $1.00 per page. We are not allowed to copy records that have been sent to us by other health care providers or facilities. We can only copy records that have been generated in this office. If you believe there is information in your record that is incorrect or missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Acknowledgement

I acknowledge receipt of this notice of information practices. I understand I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

____

Signature

____

Date

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