Patient Registration Form

Patient Last Name:		Patient First Name:	
SSN	DOB	Age	Birth Gender:
Address			Legal/Current Gender:
City	Zip	Cell Phone	
Home Phone		Work Phone	
How did you hear of us?		Spouse Still Working?	
Emergency Contact Person		Emergency Contact Phone Number	
Insured's Name		Relation to patient	
Insured's Work Phone		Insured's Home Phone	
SSN:	DOB	Age	Sex

IF YOU'RE HERE AS A RESULT OF AN INJURY, PLEASE COMPLETE THE FOLLOWING:

Date Occurred		How it occurred	
Insurance Name		Claim #	
Address			
City	State	Zip	Phone ( )

WHERE WOULD YOU LIKE US TO SEND YOUR PRESCRIPTIONS?

Local Pharmacy : (List Name/Location/City/Phone)	
Mail Order Pharmacy:	

OPTIONAL

Some third party payers (HAP and BCN) are now requiring that we provide them with our patient's Race and Ethnicity. They are using this information to track and achieve measurable reductions in racial/ethnic disparities in healthcare.

☐ Check here if you do not want to provide this information

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other	Ethnicity: ☐ Hispanic/Latino ☐ Other

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM FORMS. IN ADDITION, I REQUEST CLAIMS BE SUBMITTED ON MY BEHALF AND PAYMENT FOR SERVICES RENDERED BE DIRECTLY MADE TO EPIC PRIMARY CARE, PLLC.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR AMOUNTS APPLIED TO INSURANCE POLICY DEDUCTIBLES AND CO-PAYMENTS NOT COVERED BY MY INSURANCE COMPANY.

PATIENT/GUARDIAN SIGNATURE_____ DATE _____

PATIENT NAME: _____ **DOB:** _____

Active Medical Conditions:	**(circle all that apply)**		
High Blood Pressure	Allergies		Acid Reflux
High Cholesterol	Asthma		Diverticular disease
Coronary Heart Disease	Emphysema		Depression or Anxiety
Peripheral Vascular Disease	Anemia		Stroke
Diabetes Mellitus	Cancer		Migraines
Hypothyroidism	Type: _____	_____	Other: _____ _____

Allergies: (circle)	No Known Allergies		
Penicillin	Cephalosporins	Iodine	Food
Erythromycin	Sulfa	Contrast	Type:
Z-pack	Codeine	Latex	Other: _____
Cipro	NSAID (Motrin, Aspirin, etc)	Environmental	_____ _____

Family History: (mark in box that applies)

	Mother	Father	Brother	Sister	Other relative (specify)
High Blood Pressure					
High Cholesterol					
Coronary Artery Disease					
Congestive Heart Failure					
Peripheral Vascular Disease					
Diabetes Mellitus					
Hypothyroidism					
Asthma					
Depression					
Anxiety					
Stroke					
Migraines					
Colon Cancer					
Breast Cancer					
Prostate Cancer					
Lung Cancer					
Cancer					
Anemia					

Social History:	(circle all that apply)				
Tobacco Use	Never Smoked		Current Smoker		Former Smoker (quit_____)
Alcohol Use	Never Used		Current drinker		Former Drinker (quit_____)
Drug Use	Never Used		Current User		Former User (quit_____)
Marital Status	Single	Married	Divorced	Widowed	Separated
Sexual Preference	Heterosexual		Homosexual		Bisexual
Work Status	Working		Unemployed		Disabled
Education level	High school/GED		College		Graduate School
Exercise	<30 min/week		31-60 min/week		61-90 min/week >90 min
Diet History	<3 meals/day		3-4 meals/day		5-6 meals/day
Caloric intake	Calories/day average				

PATIENT NAME: _____

Medications: (name, dose, # of pills, frequency; ex. Tylenol 325mg 2 tabs twice/day)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Surgical: (circle all that apply)

Tonsillectomy (before 12 yrs old, after 12 yrs old)
Adenoidectomy (before 12 yrs old, after 12 yrs old)
Appendectomy
Gall Bladder
Hysterectomy (Vaginal Abdominal)
Ovary resection (Left Right Both)
Breast Biopsy
Mastectomy
Vasectomy
Prostate Resection
Inguinal Hernia
Umbilical Hernia
Epidural Injection
Valve Replacement
CABG (1 2 3 4 vessel)
Cardiac Catheter
Knee Laparoscopy
Knee Replacement
Lumbar Laminectomy
Cervical Laminectomy

Immunization:			Date:	Location:
Influenza	Yes	No	_____	_____
Pneumonia	Yes	No	_____	_____
Tetanus (Td or TDaP)	Yes	No	_____	_____
Meningitis	Yes	No	_____	_____
Shingles	Yes	No	_____	_____
Hepatitis A	Yes	No	_____	_____
Hepatitis B	Yes	No	_____	_____
Gardasil (HPV)	Yes	No	_____	_____
Tuberculosis (TB)	Yes	No	_____	_____

Health Maintenance:	Date:	Location:
Physical Exam (CWE)	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Spirometry (Asthma, COPD)	_____	_____
Diabetic Foot Exam	_____	_____
Retinal Exam	_____	_____
Glaucoma Exam	_____	_____
Abdominal Aorta Screen	_____	_____

Diagnostic Studies:

Stress test	Mammogram	Abdominal Aorta Screen
Echocardiogram	Colonoscopy	Spirometry
Cardiac catheter	Endoscopy	Leg ultrasound/doppler
Ankle Brachial Index	Electromyogram (EMG)	Electroencephalogram (EEG)

Impairments:

Deaf	Mental retardation	Cerebral Palsy	Movement disorder
Blind	Brain damage	Mood disorder	Neurological disorder

Check Off Any Current Systems

PATIENT NAME: _____ **DOB:**_____

HEART (CARDIOVASCULAR SYSTEM)

	chest pain		cramping in legs while walking		
	palpitations		awakening in the night with sudden difficulty breathing		
	dizziness/lightheaded		loss of consciousness		
	leg swelling		difficulty breathing while laying down		

LUNGS (PULMONARY SYSTEM)

	cough		cough with blood				wheezing
	difficulty breathing		excess sputum production				
	chronic cough (longer than one month)		difficulty breathing with exertion				

BOWELS (GASTROINTESTINAL SYSTEM)

	abdominal pain		bright red or maroon stools				nausea
	abdominal mass		difficulty swallowing				heartburn
	change in bowel habits		vomit with blood				vomiting
	constipation		dark black stools				diarrhea

NERVOUS (NEUROLOGICAL SYSTEM)

	decreased memory		headaches (other)				loss of coordination
	difficulty speaking		headaches (migraines)				visual changes
	difficulty walking		seizures				weakness
	numbness in limbs		vertigo (spinning)				tremor

MUSCULOSKELETAL (MUSCLE & BONE) SYSTEM

	joint redness		morning stiffness				muscle ache
	joint deformity		joint pain				muscle fatigue/weakness
	chronic/long term back pain		joint swelling				chronic/long-term neck pain

URINARY TRACT SYSTEM

	urinating frequently		urinating blood				painful urination
	awakening frequently to urinate		urinary leakage				weak urine stream

EAR, NOSE, AND THROAT

	runny nose		red eyes				sore throats
	nose bleeds		itchy/watery eyes				bad breath
	nasal congestion		oral lesions				enlarged tonsils
	snoring		excessive sneezing				ear aches
	hearing loss/muffled		ringing in the ears				vertigo

SKIN (DERMATOLOGY)

	rash		dark moles		growing skin lesions
	new skin lesion		easy bruising		slow healing cuts
	keloid/scar formation		loss of pigment		loss of hair

GYNECOLOGIC/UROLOGIC

	menopausal		change in menstruation		excessive bleeding
	painful menstruation		cyclical mood changes		breast tenderness
	breast mass/lump		nipple discharge		vaginal dryness/irritation
	vaginal discharge		penile discharge		penile lesion
	1st day last menstrual period ___/___/___		testicular pain		testicular mass

PSYCHIATRY

	depression		anxiety state		manic episode
	personality disorder		obsessive/compulsive		hallucinations
	post-traumatic syndrome		alcohol/substance addition		

ENDOCRINE/GLANDULAR SYSTEM

	weight gain		weight loss		increased thirst
	increased appetite		tremors/shaky		stretch marks
	fatigue		increased perspiration		excessive hair growth

Patient Signature:_____ Date: _____

PATIENT NAME: _____ DOB:_____

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

I, _____ hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

_____
Name of Personal Representative

The authority of this person when acting as my personal representative is restricted to the following functions:_____

Description:_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to EPIC Primary Care, PLLC. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Signature_____ Date _____

REVOCATION SECTION

I hereby revoke this designation of a personal representative.

Signature: _____ Date: _____

EPIC PRIMARY CARE

NAME OF PATIENT:_____ DOB:_____

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received the attached Notice of Privacy Practices

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

_____

NAME OF PATIENT:_____ DOB:_____

CONSENT FOR MEDICAL TREATMENT AND PROCEDURES

I, _____, request and authorize outpatient care as my physician, his/her assistant or designee (collectively called the physicians) may deem necessary or advisable. These include but are not limited to routine diagnostic radiology and laboratory procedures, routine drugs, biologicals and other therapeutic applications, and routine medical, nursing and facility care. I understand that in emergency situations it may be necessary or advisable for the physician to perform other additional or extended services beyond those contemplated at time of admission to preserve my (the patient's) life or health. I consent to these treatment services, procedures and medication therapies. I understand that facility care is directed by me (the patient), physician and the facility personnel rendering care and services to me (the patient) according to the physician's instructions and that some of the physicians who manage the care are independent physicians and not agents, representatives or employees of the facility.

X_____ _____

Patient (or person authorized to sign for patient) Date

X_____

Witness Date

PATIENT NAME: _____ DOB: _____

This is an agreement between EPIC Primary Care, PLLC, a Michigan Professional Limited Liability Company, located at 911 E 9 Mile Rd, Ferndale, MI 48220 and _____ (hereinafter referred to as "Patient") located at _____. (Your address)

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to EPIC Primary Care, PLLC.

By executing this agreement, you agree to pay for all services that are received as well as the following and subject to all of the terms and conditions set forth herein.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

☐ **Paper Statement sent to home**

☐ **Secure Electronic Statement sent via e-mail address:_____@_____._____**

Payment options:

1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. You may pay online via our patient payment portal.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service, in full.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay such co-pay or deductible at the time service is rendered. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Your Insurance policy is a contract between you and your insurance company. If we are NOT a party to this contract, we will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

After Hours Fee: There is an Evening/Weekend/Holiday surcharge of $24 that is for services provided after 5:00 PM, on a weekend, or on a federal or state holiday.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of point zero five percent (.05%) per month or an **ANNUAL PERCENTAGE RATE** of six (6%) percent. The finance charge on your account is computed by applying the periodic rate (.05%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Statement Fee: A billing fee of $10 will be imposed on each statement that is sent to Patient due to Patient's non-payment on the date of service. After the fourth consecutive statement with no Patient response, we will no longer be able to see you in our office, and you may be sent to collections.

Credit History: We reserve the right to report your account status to any credit reporting agency such as a credit bureau.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these, as it is against our contract for us not to collect co-payment for our services rendered. Any payment made on the account will be applied to the oldest balance first.

Returned checks: There is a $35 fee for any checks returned by the bank.

Missed appointment: Patients with three missed appointments may be asked to transfer their records to another doctor.

EPIC PRIMARY CARE

PATIENT NAME: _____ DOB: _____

Past due accounts: If your account becomes past due, we will take any legal steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all actual lawyers' fees which we incur plus all court costs and other charges. In case of suit, you agree that such venue shall be the courts in Oakland County, Michigan.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay up to a $125 fee, if you want to pick up a copy of your records. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Master Medical: If you have master medical, you will be required to pay all of your office visit fees at the time of service. We will bill BCBS as a courtesy to you in order for you to be reimbursed by the carrier.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Disputed Charges: We kindly request that you immediately question any disputed charges with our billing department before contacting your insurance company.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____

(Print)
Responsible Party: _____
(If not the patient)

Patient Signature:_____ _Date: _____ _____

EPIC Primary Care has been a member of the Electronic Prescribing Initiative (E-prescribe) since 2002. The goal of the **E-prescribe** Initiative is to improve the safety, quality and cost-effectiveness of the prescription process. It has been a struggle because many pharmacies were not registered or equipped to perform this bidirectional communication. Thankfully, in July 2008, the federal government implemented the Medicare Improvements for Patients and Providers Act (MIPPA) as an initial step towards mandating e-Prescribing technology. Since this time there has been much progress in the industry to comply with these standards. To act in accordance with these initiatives we need to collect additional information from each of our patients.

For our patients who use chronic prescription medications (diabetic or heart medications, etc.) it will no longer be necessary to call our office to request a refill. You can now request a refill online through our My EPIC Chart patient portal. If you do not have access to the internet or an e-mail address you will need to call your pharmacist and request that they "**submit an e-refill request to my doctor"**. Your pharmacist will know what this means.

We are excited at the success of our My EPIC Chart portal. You can sign up at www.epicpc.com. This portal allows you to send secure messages to your doctor and schedule appointments. You can use the portal 24/7 and not have to wait for the office to open to make your requests. Our portal is designed to be very secure and HIPAA compliant.

PLEASE REMEMBER THAT **EPIC PRIMARY CARE** WILL CONTINUE TO WORK HARD TO GIVE THE BEST CARE TO OUR PATIENTS. WE WILL CONTINUE TO STRIVE TO INTEGRATE ALL THE NEWEST AND LATEST ADVANCEMENTS IN THE MEDICAL INDUSTRY.

Please provide your current e-mail address as well as your preferred pharmacies. Please verify your contact information as well. *If you have already filled this out please inform the Medical Receptionist*. **Please note this form should be filled out for all of our patients including family members who are old enough to have an email address or will likely require long term medications.**

Name: _____ Address: _____ City: _____ State: _____ ZIP: _____	DOB: Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Local Pharmacy (list name/location/city/phone):

_____

_____

Mail Order Pharmacy:

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize EPIC Primary Care, PLLC It's Director or designee, or Medical Information Services Department to release information contained in my patient records, including alcohol and drug abuse records, protected under the regulations in 42 Code of Federal Regulations, Part 2, if any psychiatric psychological services records, if any, and social work, records, if any, including communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any to the individuals or organizations listed below, only under the conditions listed below:

Patients Phone Number: _____
Birth date of Patient: _____ Patient Name: _____

1. Name of person or organization to which disclosure is to be made:

- Allscripts Community Exchange

2. Specific type of information to be disclosed: All records as well as allow EPIC PRIMARY CARE to request records from previous clinicians as needed for continuation of care.

3. The purpose and need for such disclosure: Continuation of Treatment or Health Care

_____ _____ _____

Signature (patient or parent/guardian) Date

EPIC PRIMARY CARE

A Patient-Centered Medical Home is a Partnership between the Patient and Their Physician

By choosing to participate in a Patient-Centered Medical Home, I agree to:	**Being a part of a Patient-Centered Medical Home, your doctor will:**
• Make sure my doctor knows my entire medical history • Tell my doctor all of the medications I am taking • Actively participate with my doctor in planning my care • Keep my appointments as scheduled • Adhere to the action plan designed by my doctors • Consult my doctor before making my own appointment with a Specialist • Request that any other doctor I see send my doctor a report, copies of lab work, test results, and x-rays • Know my insurance and what it covers • Provide the office feedback on how they can improve their services	• Work with you to improve your health • Review your medications at every visit and discuss with you any interactions or contraindications • Electronically prescribe your medications to ensure they are accurate and available to you promptly • Develop a personal action plan with you to address your chronic conditions • Set goals with you and monitor your progress • Use computer technology to monitor your progress and determine if your health is improving • Inform you of all test results • Help you take control of your health by providing you educational material, hosting group visits and linking you to other community programs and resources • Provide you 24 hour access to a clinical decision-maker by phone • Have arrangements with after-hours care to be informed of your visit or emergent treatment within 24 hours or next business day • Reserve space in our schedule for you to accommodate a same-day appointment

Patient Name: _____

Signature:

_____

Date:_ _____

PCMH: EPIC Primary Care, PLLC

Signature:

_____

Date:

_____