PATIENT REGISTRATION FORM
PLEASE PRINT CLEARLY

Patient:

Last Name ____________________ First________________ Middle Initial____ Sr. Jr. II III _____

Date of Birth _____-______-_______ Social Security # ________-_______-_______ Gender: M /F

Marital Status: **(Circle One)** Single Married Divorced Widowed

Mailing Address ______________________________ Apt______ lot_____ PO Box #____________

City ____________________ State______ Zip Code________

Telephone #'s – Please check preferred

☐ Home # (_____) ______-_________ ☐ Cell # (_____) ______-__________

☐ Work # (_____) ______ -___________ ☐ Other # (_____) ______-_________

***Would you like information about Advanced Directives? Y/N**

Family Doctor ___________________________ City_______________

PARENT-OR-RESPONSIBLE PARTY:

Last Name: ___________________ First ________________ Middle Initial ____

Gender: M/ F Date of Birth _____-_____-_____ Social Security # _____-____-____

Relationship to Patient _________________

Mailing Address ______________________________ Apt______ lot_____ PO Box #____________

City ____________________ State______ Zip Code________

Phone # (____) _____-_______ Employer _______________________

PRIMARY INSURANCE

Insurance Name _________________ Policy Holder ____________________ Copay $___________

Policy Holder's Social Security # ______-______-_______ Relationship to patient_________

Policy Holder's Date of Birth _____-_____-______ Gender: M/ F

SECONDARY INSURANCE

Insurance Name __________________ Policy Holder ____________________ Copay $___________

Policy Holder's Social Security # ______-______-_______ Relationship to patient_________

Policy Holder's Date of Birth _____-_____-______ Gender: M/ F

I, the undersigned, a patient of Lapeer Family and Urgent Care, do hereby authorize physicians and staff of Lapeer Family and Urgent Care to administer treatment as is necessary. I understand as a courtesy Lapeer Family and Urgent Care will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Lapeer Family and Urgent Care. I am ultimately responsible for all services rendered, unless otherwise provided by law.

Patient/Parent or Guardian Signature: X______________________________ Date_______

Financial Agreement

1. **Payment is expected at the time of service**. We accept cash, checks, MasterCard, Visa, and Discover.
2. **All co-payments, deductibles and non covered services may be paid in full at the time of service.**
3. A schedule of fees for our services is available at the receptionist desk. Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance company, are your responsibility.
4. **Please be aware of specific details of your insurance plans covered benefits. This is especially important with regard to well care maximum limits and immunizations/injection coverage limits**. Do not assume that all services are covered. It is your responsibility to know the limitations of your coverage and to communicate them with our office staff prior to the delivery of service.
5. **We expect 24 hours notice for all cancellations.** We reserve the right to charge $30.00 cancellation/no show fee for appointments cancelled with less than 24 hours in advance.
6. If your insurance is a managed care plan, please review your coverage. If you or a dependant receive services that require a referral, adequate planning is essential. Referrals must be authorized by your doctor and usually require an office visit. Authorization from managed care plans for your referrals may take up to one week. **Please be aware that we are unable to accommodate same day call in requests for referrals.** Upon receipt of a referral to a specialist or ancillary service it is your responsibility to be aware what has been authorized. Subsequent visits, procedures, surgeries, and hospitalization typically require additional referrals. Do not expect the referral specialist or service to obtain approval for these additional services-this is your responsibility. Failure to obtain necessary authorizations often leads to out of pocket expense. We are happy to assist you in any way with your managed care plan; however, our experience with these plans has demonstrated that planning and adequate time are essential. Your knowledge of your plans regulations and benefits as well as adequate planning, will help avoid delays and denied claims.
7. **If you can not provide adequate proof of insurance, you will be responsible for the entire visit at the time services are rendered.**
8. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating labs. Please make us aware.
9. In care of estranged or divorce parents, **the parent accompanying the child to the visit is responsible to pay for services rendered**-regardless of coverage or insurance arrangements. We will gladly furnish you with the necessary statements for reimbursement.
10. If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.
11. Your doctor and or physician assistant is here to handle your medical care and well-being. The physicians and assistants are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial agreements with the business office staff.

I understand and accept the above statements

______________________________ ______________

Patient/Parent Signature Date

____

Guardian signature if applies

RELEASE OF CONFIDENTIALITY

I, ___________________________, understand that by signing this document I am
PATIENT NAME
allowing any trained employee by Lapeer Family & Urgent Care to reveal information in this patient chart to:

Name	Relationship	Phone Number
		( )
		( )

I will not hold Lapeer Family & Urgent Care responsible for releasing information pertaining to test results, medications, consultations or any other related items to the above named people. By signing this I also understand that I will not be notified before any information is released and that I do give permission for Lapeer Family & Urgent Care to speak to the people named above about my medical condition or medical records.

- **If the above spaces are left blank, I acknowledge that the staff of Lapeer Family & Urgent Care will not release any personal medical information to anyone but the patient OR if the patient is a minor, information is automatically given to their biological parents.**

____________________________________ __________________

Patient, Parent OR Guardian Signature ***Date***

EMERGENCY CONTACTS

1. Full Name: ______________________________ Relationship to Patient __________________

Mailing Address _________________________________Apt______ lot_____ PO Box #_______

City _____________________ State______ Zip Code________

Home # (_____) ______-_________ Cell # (_____) ______ -___________

2. Full Name: ______________________________ Relationship to Patient __________________

Mailing Address _________________________________Apt______ lot_____ PO Box #_______

City _____________________ State______ Zip Code________

Home # (_____) ______-_________ Cell # (_____) ______ -___________

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received, and/or reviewed the Notice of Privacy Practices for Lapeer Family & Urgent Care. I am aware that there are copies of this notice available for my review in the office and that I may take a paper copy of this notice if desired.

____ ____________

Patient, Patient Representative or Parent of Patient under age 18 Date

(If patient representative signs above, please describe the relationship to the patient)

STAFF USE ONLY

Documentation of "Good Faith Effort"

Patient Name: ____ Date: _____________

The patient presented for treatment on this date and was provide this practice's Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

____ Patient refused to sign, with the reason _______________________________________

____ Patient is unable to sign due to: ____

____ There was a medical emergency preventing timely signature and an attempt will be made to obtain acknowledgement later.

____Other:____

____ _______________

Signature of employee completing this form Date