MOUNT PLEASANT
MEDICAL ASSOCIATES

We want to provide you with the very best health care possible. We realize your time is valuable, and our staff will try to attend to you as quickly as possible. Please fill out the biographical information for our computer file. Use you legal name, not a nickname or abbreviated name. If you prefer to be addressed by a nickname, please let the staff know. Thank you.

****

PLEASE PRINT Date: _____

Name: _____
Last *First* *M.I.*

Street Address: _____

P.O. Box: _____ Apt. No. _____

City: _____ State: ____ Zip: _____

Home Phone: ( ) _____

Alternate Phone: ( ) _____

Social Security #: _____

Birth Date: ____/____/____ Race: _____

****Alternate address: if you are a college student or have a secondary home:**

Alternate Address: _____

P.O. Box: _____ **Apt. No.** _____

City _____ **State:** ____ **Zip:** _____

Marital status: ____married ____single ____widowed
____divorced ____ other relationship

Employment status: ___full time ___part time ___self
___not employed ___retired ___active duty

Employer: _____

Address: _____

_____

Work Phone: ( ) _____ Ext: _____

Student Status: ___full time ___part time

Spouse's Name: _____

Spouse's Birth date: _____

Spouse's Employer: _____

Employer Address: _____

_____

Employer Phone #: ( ) _____

Emergency Contact Person: _____

Phone: ( ) _____

Relationship to Patient: _____

Primary Insurance: _____

Name of subscriber: _____

Birth date of subscriber: ____/____/____ Sex: M / F

Social Security # of subscriber: _____

Relationship of subscriber to patient: _____

Subscriber Employer: _____

Employer address: _____

Secondary Insurance: _____

Name of subscriber: _____

Birth date of subscriber: ____/____/____ Sex: M / F

Social Security # of subscriber: _____

Relationship of subscriber to patient: _____

Subscriber Employer: _____

IF PATIENT IS A MINOR:

Father's Name: _____ Soc. Security #: _____ Birth date: ___/___/___

* If Different from Above-Address: _____ City: _____ State: ___ Zip: _____

Home Phone: ( ) _____ Employer: _____ Work Phone: ( ) _____

Mother's Name: _____ Soc. Security #: _____ Birth date: ___/___/___

* If Different from Above-Address: _____ City: _____ State: ___ Zip: _____

Home Phone: ( ) _____ Employer: _____ Work Phone: ( ) _____

MEDICARE & CHAMPUS AUTHORIZATION:

Patient Signature (required for billing) _____

Medicare number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mount Pleasant Medical Associates for any services furnished to me by an employed physician or practitioner. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

COMMERCIAL & MEDIGAP AUTHORIZATION:

Patient Signature (required for billing) _____

Policy number _____

I request that payment of authorized benefits be made on my behalf to Mount Pleasant Medical Associates for any services furnished to me by an employed physician or practitioner. I authorize any holder of medical information about me to release to my carrier any information needed to determine these benefits or the benefits payable for related services.

Email Address:

MOUNT PLEASANT MEDICAL ASSOCIATES

Preferred Pharmacy Information

Patients Name _____ Date of Birth _____ Date _____

Local Retail Pharmacy:

Name: _____

City: _____

Telephone/ Fax: _____

Mail Order Pharmacy:

Name: _____

Address: _____

Telephone/ Fax: _____

MOUNT PLEASANT MEDICAL ASSOCIATES

Notice of Privacy Practices Acknowledgement

I acknowledge that:

A copy of the Mount Pleasant Medical Associates Notice of Privacy Practices was made available to me at the location where I registered for and/or received health care services.

The *Notice of Privacy Practices* was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for an additional copy of the *Notice of Privacy Practices* at any future date of service or upon request.

If I came in for health care services in an emergency treatment situation, I was able to view the *Notice of Privacy Practices* as soon as reasonably practicable after the emergency treatment situation.

_____
Printed name of patient

_____ _____
Signature of patient or patient's representative Date

_____
Relationship to patient (if other than patient)

Medical Records #: _____

[If the above signature is that of a patient's representative, complete the verification section below.]

MPMA has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____ (description of authority to act, e.g. husband, wife, etc.), he/she is authorized to act on behalf of the patient.

Verification completed by:

_____ _____
Associate name and signature Date

To Be Completed By Mount Pleasant Medical Associates

If an acknowledgment is not obtained, indicate the reason why the acknowledgment was not obtained:

_____

_____

Individual delivering the Notice of Privacy Practices:_____ Date: _____

MOUNT PLEASANT MEDICAL ASSOCIATES

Release to Family and Friends Involved in Health Care

Patient's Name: _____ Birth Date: _____

Address: _____ Phone No: _____

Social Security #: _____ Medical Records #: _____

Mount Pleasant Medical Associates has always been committed to the protection of your personal medical information. We realize that in today's society your spouse, individual family members, or close friends may be involved with your care or the payment of your care. In an effort to protect your personal medical information, we need to know the individuals you wish to allow our staff to release or discuss your care or the payment of your care with.

The physicians, nursing staff and office staff have my permission to release or discuss my personal medical information Concerning the following:

- o General Medical Care
- o Billing and Accounts
- o Medications
- o Insurance Information
- o Appointments

MPMA may release or discuss my personal medical information, as indicated above, with any of the following individuals in person or by telephone.

1) _____ relationship _____

2) _____ relationship _____

3) _____ relationship _____

4) _____ relationship _____

_____ _____
Print Name of Patient Date

_____ _____
Signature of Patient or Legal Representative State Relationship to Patient

_____ _____
Signature of Witness Date

Mount Pleasant Medical Associates will not release or discuss your personal medical information with your spouse, individual family members or close friends, as indicated above, for the following:

- Any information related to sexual abuse, child abuse, other abuse, neglect, or domestic violence.
- Any information that we feel may cause or bring harm to you or someone else.
- Any information related to pregnancy, infertility, sterilization, or other related.
- Any information related to sexually transmitted diseases.
- Any information related to Acquired immunodeficiency Syndrome (AIDS), or human-immune deficiency virus (HIV)
- Any information related to alcohol or substance testing, treatment, or abuse.

If you desire our staff to release or discuss any of the above items with your spouse, individual family members or close friends you must specifically authorize, in writing for us to do so. Any MPMA staff member will assist you in doing so.
This document shall remain in effect until revised or revoked by the patient or their personal representative.
Using protected Health information For involvement in and Notification of the Patient's Care.

MOUNT PLEASANT
MEDICAL ASSOCIATES

CONSENT FOR TREATMENT

4639 EAST PICKARD STREET, SUITE B, MT. PLEASANT, MI 48858 PH# 989-817-4300

PATIENT NAME: _____ **Date of Birth:** _____

CONSENT FOR CARE AND TREATMENT: I request and consent to such care and medical treatment as deemed necessary by my physicians. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees or promises have been made to me regarding the results of any care or treatment.

TESTING FOR PRESENCE OF HUMAN IMMUNODEFICIENCY VIIRAL SYNDROME (HIV/AIDS) AND HEPATITIS: I understand that, in the event a physician, nurse, or other health care provider is exposed to my blood or body fluids, my blood may need to be tested without my consent for the presence of an infectious disease, such as hepatitis or human immuno deficiency viral syndrome (HIV). The results of the test will only be released to the exposed person and no one else unless required or authorized by the legal system. If the results indicate the patient is infected, Mount Pleasant Medical Associates will notify the patient and offer to provide appropriate counseling.

CONSENT TO USE AND DISCLOSURE OF MY MEDICAL INFORMATION: I authorize MPMA and my physician(s) to use and disclose medical information about me for the purposes of treatment, payment and hospital operations. I understand that my medical information may include information that may be related to psychiatric conditions, sexually transmitted disease such as HIV and AIDS, and treatment of drug and alcohol conditions. I understand that my consent to uses and disclosures of my health information may only be revoked in writing, but my authorization to disclose information regarding treatment for drug and alcohol conditions is effective only as long as reasonably necessary to serve the stated purposes for which it is given.

FINANCIAL AGREEMENT: I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me by MPMA and my physician(s) for application to my bill. I assume full financial responsibility for payment of all expenses associated with my care and treatment.

CHAMPUS AUTHORIZATION (if applicable): I request that payment of authorized benefits be made either to me or on my behalf to MPMA for any services furnished to me by MPMA, including physician services. I authorize any holder of medical information about me to release to CHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services.

MEDICARE CERTIFICATION (if applicable): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

The undersigned certifies that he/she has read the foregoing, and is the patient, or duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ _____

Signature of Patient or Representative Date of Signing

_____ _____

Print Name of Signer Relationship of Signer to Patient

_____

Witness

MOUNT PLEASANT
MEDICAL ASSOCIATES

Missed Appointment Policy

In order to provide quality care to our patients and maintain availability for all, our office has adopted a policy concerning missed appointments.

- A "missed appointment" is an appointment that the patient did not call our office to cancel or reschedule 24 hours in advance.
- When an appointment is missed our office will contact the patient to reschedule

However…

- If more than three appointments are missed in any six month period of time the patient risks or potentially forfeits the ability to be seen in this office as a patient

It is our hope that this will not be an issue and are only informing you of the possibility. Again, we are striving to maintain availability for you and other patients and appreciate your cooperation in this matter.

- -

I have read the "Missed Appointment Policy" in its entirety and fully understand that the above information relates to me and to my family members.

Patient's Name (Printed) _____ DOB _____

……/……

Patient/Guardian Signature Date

……

Witness

Mt. Pleasant Medical Associates
OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.

2. If we are your primary care physician (HMO, Medicaid plans etc.), make sure the Doctor's name appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.

3. **According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. This also applies to recheck and follow up visits.**

4. Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. **A $5.00 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service.

5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.

6. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

7. If we do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.

8. If you have no insurance, payment for an office visit is to be paid at the time of the visit.

9. Patient balances are billed immediately on receipt of your insurance plan's explanation of your benefits. Your remittance is due *within* 10 business days of your receipt of your bill.

10. If previous arrangements have not been made with our finance office, any balance over 90 days will be forwarded to a collection agency.

11. We require 24-hour notice for canceling any appointments. There is a $25.00 charge for routine appointments and $50.00 charge for physical/ preventive health appointments if they are not canceled OR if 24-hour notice is not given.

12. A $25.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

13. We charge $30.00 to copy or transfer medical records. Immunization records and last office visit notes can be provided free of charge.

14. Forms Completion – Forms will be completed as a courtesy during the visit if the patient provides the form at the time of the visit. If a form is processed after the visit it will incur the $20.00 charge. It's your responsibility and will not be billed to insurance

15. Not all services provided by our office are covered by every plan. Any service that is determined not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____

Patient Name(s)

_____

Responsible Party Member's Name Relationship:

_____

Responsible Party Member's Signature Date: