Mancelona Family Practice
Albert C. Brown, MD
Jennifer Leino, MD
Wesley Dean, PA-C
Alexis Kilbourn, PA-C

Phone (231) 587-9181 Fax (231) 587-0923

NEW PATIENT REGISTRATION FORM

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

☐ **I would like to sign up for the patient portal using my email address.**

Social Security Number: _____ Sex: MALE FEMALE

Employer: _____ Employer Phone: _____

Parent, Guardian, or Spouse: _____ Phone: _____

Emergency Contact: _____

Emergency Contact Phone: _____ Relationship: _____

Emergency contact is an authorized HIPAA contact: YES NO

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SSN:_____ Policy Holder's Employer: _____

I consent to any and all health care treatment and diagnostic procedures provided by Mancelona Family Practice and its physicians, clinicians and other personnel. I understand that there are certain risks associated with any form of treatment. I understand that I am responsible for updating my contact information in a timely manner, should it change.

Parents of minor children: The State of Michigan does not require parental consent for minors to receive reproductive healthcare, mental health services, and substance abuse services. We encourage families to keep open communication, but there may be times when your child consents to these types of care without your knowledge. If, in the course of treatment, we find that your child has a life-threatening condition, you will be notified.

Signature: _____ Date: _____

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HIPAA Authorization Form

Many of our patients allow family members or friends to discuss their protected health information with our staff on their behalf, such as diagnosis/treatment, test results, medications, and appointment scheduling. Due to HIPAA regulations, we are not permitted to release this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members or friends, you must sign this form.

☐ I ***DO NOT*** give permission to share my protected health information with family or friends.

☐ I give permission for Mancelona Family Practice to discuss my protected health information with the following individuals:

Name	Relationship	Phone
Name	Relationship	Phone

How would you like to receive health information from our office?

☐ Call or leave a voicemail on my cell phone
☐ Call or leave a message on my home phone
☐ Call or leave a message with one of the contacts above
☐ Mail information to my home if I can not be reached

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, I give consent for Mancelona Family Practice to use and disclose of my private health information to carry out my treatment plan. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand this this permission remains in effect until I revoke it in writing. I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand that I am entitled to a copy of the Mancelona Family Practice Notice of Privacy Practices, which can be viewed online at mancelonafamilypractice.net, or from the office directly.

Printed Name: _____ Date of birth: _____

Signature: _____ Date: _____

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FINANCIAL POLICY

1. **Insurance:** We participate with most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you do not provide us with valid insurance information, you will be responsible for the charges until this information is provided. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Auto accidents/worker's comp:** You must inform the receptionist and your provider if your visit is related to an auto accident or work injury. You will need to provide us with the necessary billing information. You will be responsible for the charges until we receive that information.
3. **Co-pays and deductibles:** All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud.
4. **Non-covered services:** Please be aware that some of the services you receive may not be covered or considered reasonable or necessary by your health plan, and you will be responsible for the non covered charges.
5. **Designated Primary Care Provider:** If your insurance company has someone other than one of our providers designated as your PCP, your claim may be denied, or you may have to pay a higher co-pay. It is your responsibility to notify your health plan that we are your primary care provider.
6. **Proof of insurance:** All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance card to verify insurance eligibility. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
7. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Failure to comply may result in your insurance company denying your claim, and you may be responsible for the balance.
8. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
9. **Self pay:** Self-pay patients will be expected to pay in full at the time of service. We offer a 20% cash discount when payment is made on the date of service.
10. **Nonpayment:** If your account is greater than 90 days past due, and you have not set up a pre-arranged payment plan, you may be sent to collections. Partial payments will not be accepted unless previously arranged with the billing department.
11. **Minor patients:** Any copay, deductible, or balance for a minor child shall be the responsibility of the minor's parent or legal guardian.

I have read and understand the Financial Policy of Mancelona Family Practice, and I agree to adhere to the policy.

Signature: _____ Date: _____

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MISSED APPOINTMENT POLICY

Please understand that when we schedule your appointment, we are reserving time with your provider, for your individual needs. When your appointment is made, an exam room is reserved, your chart is prepared, and notes are reviewed and ready for your visit.

As a courtesy, we will call you to remind you of your upcoming appointment. However, it is your responsibility to keep track of your schedule and any appointments you have made.

We understand that there may be times when you must miss an appointment due to emergencies or obligations to work or family. We kindly ask that if you must cancel or reschedule an appointment, that you do so at least 24 hours prior to your scheduled visit. This courtesy makes it possible for our staff to schedule other patients who may need to see that provider at that time.

If you miss a scheduled appointment and we do not receive notification from you to cancel or reschedule, you will receive a courtesy letter in the mail outlining this policy.

If you miss a second schedule appointment in a 12 month period without notifying us, you will receive a second letter in the mail outlining this policy, and you will be charged a $35 fee that MUST be paid in full prior to scheduling another appointment.

If you miss a third scheduled appointment in a 12 month period without notifying us, we will send you a letter in the mail dismissing you from our practice.

Signature:_____ Date: _____

419 West State Street • P.O. Box 769 • Mancelona, Michigan 49659

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PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

Do you, or have ever had any of the following medical problems? (Circle all that apply)

high blood pressure high cholesterol thyroid problems heart problems cancer
breathing problems arthritis stomach problems depression/anxiety
headaches ADHD diabetes

Please list any other medical problems you have currently, or have had in the past:

_____

_____

_____

Hospitalizations/Surgeries: _____

_____

Allergies & Reactions: _____

_____

_____

Family History

RELATION AGE ALIVE/DECEASED CAUSE OF DEATH HEALTH PROBLEMS

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Son(s): _____

Daughter(s): _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

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PEDIATRIC PATIENT HISTORY

Child's Name: _____ Date of Birth:_____

Parent/Guardians Name: _____

Did patient's mother have any problems during pregnancy? _____

Was child born premature? _____ Birth weight: _____ Birth length: _____

Did she/he have any trouble in the hospital as a newborn? _____

Did child sit, walk, talk on time or was or is it delayed? _____

Has she/he had any surgeries, hospitalizations, or serious injuries? _____

_____

Is your child up to date on vaccines? _____

Please list any medications your child is currently taking: _____

_____

_____

Does child have problems with any of the following? (Circle all that apply)

vision hearing speech heart sleeping asthma allergies

mouth/teeth eating/drinking learning/concentrating getting along with others

Has she/he ever had a seizure? _____

Does child often have vomiting, diarrhea, constipation? _____

Does child have any trouble with urination or urinary tract infections, bed wetting? _____

Hand Dominance: _____

Do you have any specific concerns about your child's health? _____

_____

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Authorization for Release of Medical Record Information

Patient's Legal Name: _____ Date of Birth: _____

I authorize the following provider to release my protected health information:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Release to: Mancelona Family Practice
419 W State Street
Mancelona, MI 49659

Telephone: 231-587-9181 Fax: 231-587-0923

Information to be disclosed (please include dates where applicable):

☐ Office Notes ☐ Diagnostic Reports ☐ Laboratory Reports ☐ Complete Health Record

☐ Specific Conditions _____ ☐ Other_____

Purpose of Release: _____ Are you leaving the practice? ☐ Yes ☐ No

☐ Continuation of Treatment ☐ Legal or Insurance ☐ Personal ☐ Other_____

I understand that this authorization will NOT include the following information unless indicated and initialed below:

___AIDS or HIV Infection ____Sexually Transmitted Disease Information

____Behavioral Health Care/Mental Health Services ____Treatment for alcohol and/or drug abuse

I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Patient or Legal Representative: _____ Date: _____

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SOCIAL HISTORY

Marital status: single married divorced widowed	**Women Only**
Do you exercise regularly? yes no	Age when periods began:
What is your dominant hand? left right	Have you had a hysterectomy?
Do you consume caffeine? yes no	Do you still have your cervix?
If yes, what is your usual drink and how many per day?	Do you still have your ovaries?
Do you drink alcohol? yes no If yes, how often?	Date of last pap smear: Have you ever had an abnormal pap?
Do you use tobacco or nicotine? yes no How many packs per day? What age did you start smoking?	Date of last mammogram? Have you ever had an abnormal mammogram?
If you quit smoking, when did you quit?	Do you perform regular self breast checks?
Do you use a cane, walker, or wheelchair?	Have you reached menopause?
Date of last Colonoscopy:	What do you use for birth control?
Date of last DEXA/ bone density scan:	Number of pregnancies:
Date of last Zostavax (shingles):	Number of live births:
Date of last Influenza (flu) Vaccine:	
Date of last Pneumococcal Vaccine:	**Men Only**
Date of last Tetanus Shot:	Date of last PSA test: Result:
Date of last Eye Exam:	
Preferred pharmacy:	Mail order pharmacy:

List any medications that you are taking. (Prescriptions, over the counter, vitamins, herbs, supplements)
Medication name: Strength: How often:

_____

_____

_____

_____

_____

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Termination

If Mancelona Family Practice finds it necessary to end our patient/caregiver relationship, you have the right to receive advance written notice explaining the reason for the decision, and you will have 30 days to find other healthcare services. However, Mancelona Family Practice can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the staff and/or other patients.

Reasons for dismissal may include:

1. Failure to follow Mancelona Family Practice policies.
2. Intentional failure to disclose necessary information concerning your medical conditions, including failure to disclose the use of current or past medications.
3. Intentional failure to follow the recommended treatment plan established by your provider.
4. Creating a threat to the safety and wellbeing of staff and/or other patients.
5. Violation of the controlled substance contract.

Mancelona Family Practice does not routinely prescribe controlled substances, and will not prescribe any controlled substances during any new patient visits. As a general guideline, Mancelona Family Practice will not prescribe controlled medications to any patient who has obtained them from another physician.

Signature: _____ Date: _____