Registration Form

Date ____________________

Patient Information

Patient Name: ______________________________ Date of Birth: ____________
Last, First

Home Phone: ____________ Cell Phone: ____________ Last Four Digits of SSN: ______

Address: ______________________________ City: ____________

State: ____________ Zip Code: ________ County: ____________

Ethnicity: ❒ Hispanic, Latino or Spanish origin ❒ Non Hispanic, Non Latino or Non Spanish origin

Race: ❒ African American/Black ❒ Caucasian/White ❒ Middle Eastern ❒ Asian ❒ Greek ❒ Hispanic ❒ Indian ❒ More than one race ❒ Native American Indian ❒ Native Hawaiian or other Pacific Islander

Marital Status: ❒ S ❒ M ❒ D ❒ W **Gender:** ❒ M ❒ F

Preferred Language: ❒ English ❒ Other ____________

Patient Employer: ______________________ ❒ Retired

Preferred Method of Communication: ❒ Home ❒ Work ❒ Cell ❒ Portal ❒ Other: ____________

Would like to receive appointment reminders and promotional text messages: ❒ Yes ❒ No

E-Mail Address: ______________________________

Emergency Contact Name: ______________________________
Last, First

Emergency Contact Phone Number: ____________ Relationship to Patient: ____________

Pharmacy

We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:

Local Pharmacy: ______________________ Phone Number: ____________

Address: ______________________ City: ____________
(street address if known or main road with closest cross street)

Mail Order Pharmacy: ______________________ Phone Number: ____________

Address: ____________ City: ________ State: ______ Zip Code: ______

Primary Care Family Physician/Referring Physician

Name: ______________________________

Address: ______________________________

City: ____________ State: ______ Zip: ______ Phone: ____________

Patient Signature: X ______________________ Date: ____________

See side two for health history

Health History

Date ______________________

Patient Name: ____ Date of Birth: ______________

Past Surgeries	Date of Surgery

Recent Hospitalizations

Name of Hospital	Reason for Admit and Physician Seen	Date

Medications

Current Medication	Dosage (mg)	How Often Taken

Have you ever been diagnosed with: ***(check box in all that apply)***

- ❐ Asthma
- ❐ High Cholesterol
- ❐ High Blood Pressure
- ❐ Low Blood Pressure
- ❐ Stroke
- ❐ Seizures
- ❐ A.S.H.D.
- ❐ C.O.P.D
- ❐ Anemia
- ❐ Arthritis
- ❐ Migraine Headaches
- ❐ Kidney Disease
- ❐ Rheumatic Fever
- ❐ Heart Murmur
- ❐ Depression/Anxiety
- ❐ Diabetes
- ❐ Congestive Heart Failure
- ❐ Thyroid Problems
- ❐ Heartburn (Reflux)
- ❐ Atrial Fibrillation
- ❐ Glaucoma
- ❐ Digestive Disorders
- ❐ Prostate Enlargement
- ❐ Cancer *(Type)* ____________
- ❐ Liver Disease
- ❐ Ulcers

Allergies

Name of Medication	Type of Reaction

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

____ ______________
Print Patient Name (Last, First, Middle Initial) Date of Birth

1. Authorization

I authorize APC Physicians, PLLC to disclose the protected health information described below to the following. Please list name and relationship to patient.

____

____

____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

❒ All past, present, and future periods **OR** ______________ to ______________.

3. Extent of Authorization

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X____
Signature of patient or personal representative Date

____
Personal representative and his or her relationship to patient

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY

Print Patient Name (Last, First, Middle Initial) ______________________ Date of Birth ______________

PLEASE READ THIS ENTIRE GENERAL CONSENT PRIOR TO SIGNING

GENERAL CONSENT FOR MEDICAL SERVICES

I give permission to the physicians, employees, and other people who work for or represent APC Physicians to provide me with health care services. These services could include things such as tests to determine whether I am sick, physical exams, surgery, and normal medical tests and procedures (e.g., blood tests or flu shots). My physician will help me decide what services or supplies I will need.

CONSENT TO RELEASE OF MEDICAL INFORMATION

I understand that my medical information may be used by APC Physicians and shared with other people or organizations, such as my insurance company and other health care providers, if the information is needed for reasons related to treatment, payment, or health care operations.

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

By checking one of the boxes below, I am stating that:

- ☐ I have received a copy of the APC Physicians Notice of Privacy Practices.
- ☐ I have been given the opportunity, but do not want to receive a copy of the APC Physicians Notice of Privacy Practices.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance. If you fail to present the correct insurance, you may be billed due to lack of authorization or timely filing.
- Patients are responsible for payment of copays, coinsurance, deductible and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur and are responsible for payment of additional charges, if applicable, these charges may include: Charge fee for returned checks - $27.00

ASSIGNMENT OF BENEFITS

I give APC Physicians the right to receive all of the money that my insurance company would normally pay to me for any services I receive from APC Physicians. I understand that any positive balance in my APC Physicians account may be used by APC Physicians to pay any amount I owe APC Physicians for services I receive. If there is any amount remaining in my account after paying for what I owe, APC Physicians will pay (refund) that amount to me.

By signing below, I am saying that I have read and understand this General Consent, and I agree that the terms will apply to me.

X ____ ______________

Signature of Patient or Patient's Legal Representative if Patient unable to sign Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We are committed to protecting medical information about you. This Notice describes our privacy practices and that of all its employees and staff. This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Give you this Notice of our legal duties and privacy practices with respect to medical information about you;
- Make sure that medical information that identifies you is kept private; and
- Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways we use and disclose health information that identifies you ("Health Information"). For each category we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who need the information to provide you with medical care.

Payment. We may use and disclose your Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about services you received at our office so your health plan will pay us or reimburse you for the services.

Health Care Operations. We may use and disclose Health Information for health care operations. These uses and disclosures are necessary to make sure that our patients receive quality care and to operate and manage our office. For example, we may use Health Information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Business Associates. We may disclose Health Information to our contracted Business Associates that perform functions on our behalf. For example, we may use another company to perform billing services.

Appointment Reminders, Treatment Alternatives and Health-Related Benefits and Services. As part of treatment activities or health care operations, we may use your Health Information to contact you as a reminder that you have an appointment with us. We also may use Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved In Your Care or Payment for Your Care. When appropriate, we may share your Health Information with a person who is involved in your medical care or payment of your care, such as your family or a close friend, so long as you have not objected and it is reasonable for us to believe that such disclosure is in your best interest. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Special Purposes When Permitted or Required by Law. We may disclose Health Information about you for special purposes when permitted or required by law, including the following:

- To avert a serious threat to health or safety against you, the public, or another person.
- For public health and administrative oversight activities such as disease control, abuse or neglect reporting, health and vital statistics, audits, investigations, and licensure reviews.
- For organ and tissue donation and transplant activities.
- For workers' compensation or similar programs purposes, such as for the payment of benefits for work-related injuries.
- To coroners, medical examiners, and funeral directors to identify a deceased person, determine cause of death, or to carry out duties.
- For judicial and administrative proceedings in response to a subpoena, court order, or administrative order, if certain requirements are met.
- For law enforcement activities, if the disclosure is required by law, necessary to identify or locate a suspect or missing person, about criminal conduct on our premises, about inmates, about victims of crime under certain circumstances, and in certain emergency situations.
- For U.S. military and veteran reporting obligations regarding members and veterans of the armed forces of U.S. or foreign military.
- For national security and intelligence activities, such as protective services for the President and other authorized persons.
- When otherwise required by law.

State and Other Federal Laws. We will comply with all applicable state and federal laws. *For example, under Michigan law, there are more limits on the disclosure of mental health information, substance abuse information, and HIV and AIDS information.* We will continue to abide by all applicable state and federal laws.

Other Uses of Medical Information Require an Authorization. Other uses and disclosures of your Health Information that are not covered by this Notice will be made only with your authorization, including for marketing purposes or sale of Health Information. A written authorization is also required for most uses or disclosures of psychotherapy notes.

If you provide us an authorization to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your Health Information for the reasons covered by the written authorization. You understand that we are unable to take back disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide to you.

HEALTH INFORMATION EXCHANGE

We may participate in a health information exchange organization ("HIE") that permits computer-based transfer of Health Information directly between healthcare providers at different locations and institutions to facilitate your care and treatment. If you do not want your Health Information to be shared in this way, you can opt-out.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have many rights with regard to your Health Information. If you wish to exercise any of these rights, we ask that you submit your request in writing.

Your Right to Access. You have the right to inspect and obtain a copy of your Health Information. This includes medical and billing records. You have the right to request this information in a particular electronic form or format. You also have the right to request that we transmit a copy of your Health Information directly to you or another person designated by you. We have up to 30 days to make your Health Information available to you and we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or other state or federal need-based program. We may deny your request in certain limited circumstances.

Your Right to Amend. If you feel that your Health Information is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason that supports your request for an amendment.

Your Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of your Health Information. This is referred to as an "accounting of disclosures." Your request must state a time period. We may limit the time period to the prior 6 years. The first list you request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list.

Your Right to Request Restrictions. You have the right to request a restriction or limitation on the how we use or disclose your Health Information for treatment, payment or operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care, like a family member or friend. We have the right to deny your request, except if you have paid for the service out of pocket in full and you request that we not submit your information to your health plan. In this case, we must agree to the request.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request.

Right to Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with APC Physicians. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Your Right to Receive Notice of a Breach. You have the right to be notified of a breach of your unsecured Health Information. We will notify you by mail at your last known address.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this Notice. We reserve the right to make the revised Notice effective for Health Information we already have about you, as well as information we receive in the future. We will post a copy of the current Notice at our offices and make copies available upon request.

PRIVACY NOTICE CONTACT INFORMATION

For questions about any information contained in this Privacy Notice, contact:

APC Physicians, PLLC
6742 Park Avenue
Allen Park, MI 48101
(313) 928-2333