Today's date: PCP:

PATIENT INFORMATION

Last Name: First Name: Middle Initial:

DOB: Sex: ❑ M ❑ F

Cell Phone: ( ) Appointments will be sent by Instant messaging

Home phone number or alternate phone number .:( )

Street Address: City: Zip Code:

Email Address:

Occupation Work Number:

Do you use My Beaumont Chart? Yes No

Social Security Number:

Spouses Name: Marital status: Single / Mar / Div / Sep / Wid

Emergency contact Name: Phone Number:

Insurance Information- Please Fill out all Sections that apply

Medicare	Medicare Number: Effective date:	
Medicaid	Medicaid ID Number:	PCP:
Blue Cross, BCN Blue Preferred	Policy holder Name: Policy holder DOB:	Relationship to policy holder :
	Group Number :	Service Code:
	Contract Number:	Employer Name:
Other Insurance	Insurance Name:	Insurance Phone Number:
	Insurance Address:	City State Zip Code
	Group Number:	Member ID:
	Plan:	
	Policy Holders Name:	Relationship to Policy holder:
	Social Security Number:	Group or Policy Number:

PLEASE READ AND SIGN IMPORTANT INFORMATION ON THE BACK OF THIS FORM

TERMS OF SERVICES

Effective January 2nd 2017 all standardized copays and balances will be paid at check in to improve patient flow. Insurances **require that all copays must be paid at the time of the visit.**

Authorization for Treatment: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my Provider at Center for Preventive Medicine (CPM) considers to be necessary. I may be offered medical services via evisits and telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I may participate in group visits alone or with a guest. I consent to sharing health related information with the group. Both my guest and I shall maintain confidentiality about all information discussed in the group setting. I understand that my medical care and treatment may be provided by other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization to Release Medical Information: I authorize CPM to release all medical information as necessary to:

All Payers for processing health care claims or value reimbursement programs;

- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law.
- I authorize CPM and my insurer(s) to share my past, current and future health, treatment and account records about services I've received from CPM and other care providers as needed to manage or coordinate my care and to improve the quality of that care.
- A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize CPM to access any of my health information that is available in an HIE, and CPM will also make my CPM health information available through HIEs in which it participates
- Use of Phone: I agree CPM and affiliates may use an automated telephone dialing system, pre-recorded messages, and texting, to contact the wireless number(s) and/or residential lines I provide to CPM for appointment and payment purposes.

Authorization to Assign Benefits and Release Information to CPM:

I authorize my Payer(s) to pay directly to CPM any benefits due under the terms of my health care plan(s), for services provided by CPM. I understand CPM reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to CPM on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to CPM or if CPM chooses not to accept assignment of medical benefits, I agree to pay CPM all health care payments I receive for services. I authorize CPM to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to CPM

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), other than billing terms and restrictions under a government program. I authorize CPM to apply any credit balance on my account to any amounts that I may owe to one or more CPM providers. I agree that CPM is not responsible for costs incurred if I fail to adhere to mandates from my insurance company including failure to obtain appropriate prior authorizations or referrals or care by non approved facilities or providers . I understand that CPM may charge for missed appointments if it does not receive 24 hr notice. I understand that a billing surcharge may occur on patient balances

Notice of Privacy Practices: I acknowledge that I may review CPM Notice of Privacy Practices, which can be viewed at the front desk. I can request a paper copy during my visit

Signing below means that you have received and understand this notice and you may also receive a copy.

Signature:_____Date:_____