Prism Medical Group—Bering and Weiermiller

A division of Arcturus Healthcare PLC

1055 South Blvd E Ste 220, Rochester Hills, MI 48307

REGISTRATION FORM

Today's Date:		Social Security Number:		
PATIENT INFORMATION				
Last Name:	Middle Initial:	**Marital status:** Single Married Divorced Widowed Separated		
First Name:		Birth date: / /	Age:	Sex:
Address: [Address/ P.O Box, City, ST ZIP Code]				
Please circle your primary phone: HOME CELL	Home phone no.:	Cell phone no.:		
Preferred Appointment Reminder Method: **Please select only one**	o Call to: #_____ o Text to: #_____ o E-mail to: _____			
Occupation:	Employer:			
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for bill:	Birth date: / /	Address (if different):	Phone no.:	
Insurance Subscriber's name (person who provides the insurance):		Subscriber Date of Birth: / /		
Patient's relationship to subscriber:				
IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):	Relationship to patient:	Phone Number:		
Do you have an Advance Directive? (Please circle) YES NO				
HEALTH INFORMATION RELEASE				
I request that the following person(s) to receive information regarding my protected health information: Name: _____ Relation: _____ Name: _____ Relation: _____				

With my consent Prism Medical Group, a division of Arcturus Healthcare PLC may mail to my home or other designated location, or contact via electronic exchange, any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards or test results. I have a right to request Prism Medical Group, a division of Arcturus Healthcare PLC restrict how it uses or discloses my personal healthcare information to carry out treatment, payment, and healthcare operations. This practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorized payment of insurance benefits directly to Prism Medical Group, a division of Arcturus Healthcare PLC I agree that I shall be legally responsible for any medical or surgical charge incurred in the course of my treatment, including those that are rejected as copay, deductible, or unpaid service, in excess of any hospitalization of health insurance that might be applicable.

I assign payment of authorized benefits to Prism Medical Group, a division of Arcturus Healthcare PLC on my behalf for services rendered. I understand I am responsible for the charges not covered by my health insurance policy. I am also required to pay my copay at the time of service. If not, I will be billed $25.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Prism Medical Group, a division of Arcturus Healthcare PLC may decline to provide treatment to me.

By signing this form, I am consenting Prism Medical Group, a division of Arcturus Healthcare PLC the use and disclosure of my personal health information to carry out treatment, payment, and healthcare operations. I request and authorize medical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care.

CONSENT TO TESTING

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues, or products may be obtained and that tests will be performed upon such fluids, and products and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS), my physician will counsel me and I will be given a choice of consenting in writing to such testing. I have been informed that my written consent to testing HIV antibody or other communicable diseases is not required by law in situation where a health care provider sustains an exposure to my blood or bodily fluids.

Patient/Guardian signature **Date**

PATIENT CONSENT FOR USE, TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Prism Medical Group, a division of Arcturus Healthcare PLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Prism Medical Group, a division of Arcturus Healthcare PLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent. Prism Medical Group, a division of Arcturus Healthcare PLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have access to this office's Notice of Privacy Practices Form.

Patient/Guardian signature **Date**