Birmingham Royal Oak
Medical Group, PC

5130 Coolidge Highway Royal Oak, MI 48073
Phone (248) 288-9500 Fax (248) 288-0044

☐New Patient ☐Update

| EMAIL ADDRESS: | | PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL): | |
|---|---|---|---|
| PATIENT'S DATE OF BIRTH | ADDRESS: | | CITY: |
| STATE: | ZIP | HOME PHONE: | CELL PHONE: |
| PATIENT EMPLOYER NAME | PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP) | | EMPLOYER PHONE |

**INSURED/RESPONSIBLE PARTY INFORMATION**

| NAME (FIRST -- LAST -- MIDDLE INITIAL): | | ADDRESS (If different from patient) | | |
|---|---|---|---|---|
| HOME PHONE: | WORK PHONE | SSN | BIRTH DATE: | EMPLOYER |

**PRIMARY INSURANCE INFORMATION**

| PRIMARY INSURANCE NAME: | | SECONDARY INSURANCE NAME: | |
|---|---|---|---|
| GROUP NUMBER: | ID NUMBER: | GROUP NUMBER: | ID NUMBER: |
| PRIMARY DOCTOR/FAMILY DOCTOR: | PRIMARY DOCTOR/FAMILY DOCTOR PHONE/FAX NUMBER: | REFFERING DOCTOR: | REFFERING DOCTOR PHONE/FAX NUMBER: |
| IN CASE OF EMERGENCY CONTACT: | RELATIONSHIP: | PHONE NUMBER: | |

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to Birmingham Royal Oak Medical Group for any services furnished to me by that physician/facility/supplier. I Authorize any holder of medical information about me to release to the centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized benefits be made on my behalf to Birmingham Royal Oak Medical Group for any services furnished to me by that physician/facility/supplier. I authorize any holder of medical information about me to release to (carrier's name) and its agents any information needed to determine these benefits or the benefits payable for related services.

If I refuse to sign a permission form to submit medical information to the insurance carrier for payment, the Doctor may refuse services or I (patient) may be held responsible for the cost of the services.

I understand that:

- Once "Birmingham Royal Oak Medical Group" discloses my health information by my request, it Cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws Governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission.
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

| SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | DATE |
|---|---|
| | |

Birmingham Royal Oak
Medical Group, PC

5130 Coolidge Highway Royal Oak, MI 48073
Phone (248) 288-9500 Fax (248) 288-0044

# PATIENT MEDICAL HISTORY

| **Allergies** | | | | |
|---|---|---|---|---|
| ☐ NONE/No Known Allergies | ☐ Codeine | ☐ Cipro | ☐ Anesthesia | ☐ Wheat |
| ☐ Penicillin | ☐ Morphine | ☐ Iodine/Shellfish/Contrast Dye | ☐ Latex | |
| ☐ Sulfa Drugs | ☐ Aspirin | ☐ Dairy Products | ☐ Adhesive Tape | |
| **OTHER:** | | | | |

**SOCIAL HISTORY**

**Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

**Occupation:** _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

**Surgical History:** Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

| TYPE OF SURGERY | YEAR or DATE | DOCTOR |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**Personal/Family History (Current & Prior Medical Problems):**

| Diagnosis or condition | Personal | Family/Relationship | Vaccine/Date |
|---|---|---|---|
| Diabetes | | | Flu Shot Y/N |
| Hypertension | | | Pneumococcal Vaccine Y/N |
| High Cholesterol | | | Tetanus Y/N |
| Heart Attack | | | Hepatitis B Y/N |
| Heart Stent/ angioplasty | | | Shingles Y/N |
| Heart failure | | | HPV Y/N |
| COPD | | | Reason for Hospitalization/ Date |
| Stroke | | | 1. |
| Cancer (type) | | | 2. |
| Bleeding or Clotting Problem | | | 3. |
| Kidney or Liver Problem | | | 4. |
| Immunocompromised HIV, Oral steroid, etc | | | 5. |
| other | | | 6. |

**Medications:** List any medications you are currently taking (please include over the counter medications):

**PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE**

| MEDICATIONS | ☐ None | |
|---|---|---|
| 1. | 6. | |
| 2. | 7. | |
| 3. | 8. | |
| 4. | 9. | |
| 5. | 10. | |

| **PRINT NAME** | **DATE** |
|---|---|
| **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** | **DATE** |

Birmingham Royal Oak
Medical Group, PC

# Patient Financial Policy

To eliminate confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, MasterCard, Discover, American Express, Checks and cash.

- I am responsible for knowing my insurance Benefits. Not all providers at Birmingham Royal Oak Medical Group participate with all insurances, and it is up to me to request in network provider per my health insurance. If I agree to be seen by a physician/clinician that does not participate with my insurance I agree to pay the amount accordingly for ALL services rendered.
- Billing to my insurance is no guarantee of payment, and I will pay all balances that are not covered by my insurance.
- I agree to resolve any insurance problems that the Birmingham Royal Oak Medical Group cannot.
- I understand that there is a charge of $30.00 for returned checks.
- In the events that the account is placed in collection, I will be responsible for the collection fees. In the case that I am uninsured, I agree to pay for my visit at the time of service.

**Minor Patients**

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.**

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

Birmingham Royal Oak
Medical Group, PC
5130 Coolidge Highway
Royal Oak, MI 48073
Phone (248) 288-9500 Fax (248) 288-0044

**Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I _____, understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have specific rights to privacy regarding my protected health information. I am aware that this information can be used for treatment, payments, and other healthcare operations.

I understand that Birmingham Royal Oak Medical Group Notice of Privacy Practices containing a full description of the uses and disclosure of my protected healthcare information. Notice of Privacy Practices was posted in a clear and prominent place where I was able to read and obtain a copy of the notice.

In addition, I understand Birmingham Royal Oak Medical Group reserve the right to change its notice and practices, in accordance with Section 164.520 of the code of Federal Regulation. I also understand that refusing to sign this consent or revoking this consent, then this organization may refuse to treat me as permitted by section 164.520 of the Code of Federal Regulation.

*I wish to have the following restriction with regard to the use or disclosure of my health information.*

Name: _____ Name: _____
Relationship_____ Relationship: _____
Phone number (  ) ____-_____ Phone Number: (  ) ____-____

Patient's signature: _____ Date: _____
Print name: _____