

Pediatric Associates of Livingston, PLLC
Registration Form

Patient's Name _____ Birth Date _____
Last First MI

Address _____
Street City State ZIP

Home Phone () _____ Social Security # _____ Sex M F

Referring Physician _____ Referring Clinic _____

If not referred, how did you hear about us? Previous Patient of (please circle) Dr. Baumeier Dr. McEwen Dr. Hoffman
 Friends/Family _____ Insurance Co Yellow Pages Website Sign Ad Other

Parent's Name _____ Last First MI
Address _____ Street
_____ City State Zip
Home Phone _____
Work Phone _____
Cell Phone _____
Email _____
Employer _____
Address _____
Occupation _____
Date of Birth _____

2 nd Parent's Name _____ Last First MI
Address _____ Street
_____ City State Zip
Home Phone _____
Work Phone _____
Cell Phone _____
Email _____
Employer _____
Address _____
Occupation _____
Date of Birth _____

Insurance Information

Primary Insurance
Policy Holder Name _____
Relationship to Patient _____
Insurance Co. _____
Effective Date _____
SSN _____
Date of Birth _____ CoPay _____
ID/Contract # _____
Group/Plan# _____

Secondary Insurance
Policy Holder Name _____
Relationship to Patient _____
Insurance Co. _____
Effective Date _____
SSN _____
Date of Birth _____ CoPay _____
ID/Contract # _____
Group/Plan# _____

Emergency Contact Name (someone who does not live with patient) _____

Relationship to Patient _____

Phone Numbers: (home) _____ (work) _____ (cell) _____

Please give your insurance card to the receptionist

Signature _____ Date _____
Print Name _____ Relationship to Patient _____

Pediatric Associates of Livingston, PLLC
Authorization For Services

1. Consent for medical treatment

I, _____, freely consent to any routine medical, diagnostic, therapeutic or minor surgical procedure that may be recommended by my doctor and performed by, or under the supervision of, my doctor. Specific procedures will be explained to me along with the expected benefits and possible risks prior to any procedure being conducted. I know that I can ask questions at any time and will do so if I have any questions or concerns. I recognize that the practice of medicine and surgery is not an exact science; no one can make promises or assure me about the results of any examination, treatment or procedure that I receive.

Note: State relationship if patient is unable to sign

Patient Signature (18 or older or Parent/Guardian
or Legally Appointed Representative)

Date

2. Authorization for Release of Patients Records

I authorize Pediatric Associates of Livingston, PLLC to release information contained in my patient records to the party responsible for payment of my care, including but not limited to the Medicare/Medicaid programs, my insurance carrier, my employer's insurance carrier, and/or any other party, including a family member or other individuals, whom I have indicated will be responsible for payment of my care. I intend that this authorization for release of patient information to these parties shall extend to any information including alcohol and drug abuse treatment (protected under the regulations in Code 42 of the Federal Regulations, Part 2), if any; information about mental health services and social services, including communications made by me to a social worker or mental health professional. Further, this authorization will include release of information about the diagnosis or testing for HIV (Human Immunodeficiency Virus) AIDS (Acquired Immunodeficiency Syndrome) and ARC (AIDS Related Complex) and records of any other communicable diseases.

Note: State relationship if patient is unable to sign

Patient Signature (18 or older or Parent/Guardian
or Legally Appointed Representative)

Date

3. Authorization for Payment of Insurance Benefits

I authorize payment of insurance benefits, including Medicare/Medicaid benefits, to be made directly to Pediatric Associates of Livingston, PLLC. I understand that I am financially responsible to Pediatric Associates of Livingston, PLLC (including physician, nurse practitioner) for services not covered or payable by my insurance carrier. I further understand that my provider is under no duty or obligation to seek payment from an insurance carrier before requesting full or partial payment from me.

Note: State relationship if patient is unable to sign

Patient Signature (18 or older or Parent/Guardian
or Legally Appointed Representative)

Date

4. FOR YOUR INFORMATION:

In accordance with the Michigan Public Health Code, if a health professional or other office personnel experiences an exposure to your blood or other body fluids, you may be tested for evidence of the HIV virus. The cost of the test will not be charged to you or your insurance company. The performance and the results of this test are confidential. This information will not be released without your written consent, except to those individuals or organizations that have been given access by law, who are also required to keep your records confidential.

Pediatric Associates of Livingston, PLLC
Acknowledgement of Notice of Privacy Practices

I acknowledge:

A copy of the provider's Notice of Privacy Practices was made available to me at Pediatric Associates of Livingston, PLLC. A copy of the Notice of Privacy Practices was made available for me to keep if I desired.

The Notice of Privacy Practices was posted in a clear and prominent location where I could read it.

If I came in for health care services in an emergency situation, I was able to view the Notice as soon as reasonably possible after the emergency situation.

I received the Notice of Privacy Practices no later than the first day I received health care services in person. If I received health care services by telephone/cell phone or electronically, a copy of the notice was mailed to me or sent to me electronically.

_____ Patient's Name (Please Print)	_____ Date of Birth	_____ Patient's Name (Please Print)	_____ Date of Birth
_____ Patient's Name (Please Print)	_____ Date of Birth	_____ Patient's Name (Please Print)	_____ Date of Birth
_____ Patient's Name (Please Print)	_____ Date of Birth	_____ Patient's Name (Please Print)	_____ Date of Birth

Signature of Patient or Personal Representative

Date

Signature of Workforce Member

Date

For Office Use Only: If an acknowledgement is not obtained, document below provider's good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained:

Individual's Name: _____

Date of attempt to obtain Acknowledgement: _____

Reason Acknowledgement was not obtained:

- Individual declined to sign acknowledgement
- Individual stated that he/she already received a copy of Notice and Opportunity to Agree or Object.
- Individual arrived under emergency circumstances
- Individual was not present to sign acknowledgement (services provided via telephone/cell phone/electronically/through 3rd party)

Acknowledgement form, Notice of Privacy Practices and Opportunity to Agree/Object:

- Sent with individual's Pharmacy prescription
- Mailed within one (1) business day
- Provided electronically at time of services, with return receipt requested
- Date Returned Receipt Received: _____ (if greater than 2 working days from date of service, assume transmission has failed and mail documents)
- Other _____

Signature of Workforce Member

Date