Patient Registration Information

Patient Name: ______________________________ Date of Birth: ____________

Sex: M F single/married/widow/divorced SS#__________

Race: ___ White ___ Black ___ Asian___ Indian/Alaskan ___Other ___ Declined

Ethnicity: ___ Hispanic ___ non-Hispanic ___ Declined Military Service: ____________

Home Address: ____________________City: ____________ State: _____ Zip: ______

Home Phone: ______________ Cell phone: ______________ Work: ___________

Email: ______________________
Preferred Methods of Communication: _____ Portal/Email _____Phone _______ Text

Emergency Contact: __________________ Relationship: _____________ Phone: __________

If Minor- Names of Parents:
Mother: _______________Phone Number: ____________ DOB: __________
Father: _______________ Phone Number: ____________DOB: __________

PRIMARY INSURACE

Name of Insured: ______________________ Insured's Date of Birth: __________
Relationship to Patient: _______________
Policy Plan Name: ___________________ Plan Policy Number: _______________
Group Number: _________________ Co-Pay: $ _______

SECONDARY INSURANCE

Name of Insured: ______________________ Insured's Date of Birth: __________
Relationship to Patient: _______________
Policy Plan Name: ___________________ Plan Policy Number: _______________
Group Number: _________________ Co-Pay: $ _______

Patient/Guardian Signature: ______________________________ Date: __________

HEALTH HISTORY

Confidential

Patient Name ______________________ Today's Date ______________

Age ______ Birthdate ______________ Date of last physical examination ______________

What is your reason for visit? ______________________

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________

Date of last Pap Smear __________

Have you had a mammogram? __________

Are you pregnant? __________

Number of children __________

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Pacemaker
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications or substances
Pharmacy Name Phone	

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates.____________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____
Signature of Patient, Parent, Guardian, or Personal Representative

____
Date

____
Please print name of Patient, Parent, Guardian, or Personal Representative

____
Relationship to Patient

____
Reviewed By

____
Date

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease		Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS

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	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ Signature of Patient, Parent, Guardian, or Personal Representative

______________________________ Date

______________________________ Please print name of Patient, Parent, Guardian, or Personal Representative

______________________________ Relationship to Patient

______________________________ Reviewed By

______________________________ Date

AUTHORIZATION AND AGREEMENTS OF MEDICAL TREATMENT AND INSURANCE BENEFITS

Consent For Examination: I understand that medical treatment may be necessary for the patient by the Providers of Brighton Family Physicians.

I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated lies with me and not with the Providers of Brighton Family Physicians. I hereby release my examiner from all responsibility in connection with the exam.

Consent For Treatment: I understand that medical treatment is necessary for the patient by the Providers of Brighton Family Physicians. I hereby consent to treatment to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgement of the Providers of Brighton Family Physicians. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

1. If your insurance is a managed health plan, please review your coverage. If you need services that require a referral, adequate planning is essential. Referrals must be authorized by your Provider and usually require an office visit. Authorization from managed health plans for referrals may take five to seven days to receive approval from your plan. Failure to obtain necessary authorizations can lead to out-of-pocket expenses. We are happy to assist you in any way with your managed health plan, however our experience with these plans has demonstrated that planning and adequate lead times are essential. Your knowledge of your plan's benefits and regulations as well as adequate planning will help avoid delays and denied claims.
2. In the case of estranged and divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered which may include co-pays, deductibles, and non-covered services, regardless of coverage arrangements. We will gladly furnish you will necessary statements for reimbursement.
3. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab and inform Brighton Family Physicians of your plan's requirements.
4. Your Provider is here to manage your medical care. The Physicians are not experts on insurance and cannot be aware of all financial arrangements, please direct any questions to the front office business staff.
5. If you are experiencing financial difficulties, please discuss this with the front office business staff. We will gladly work with you to make payment arrangements, however accounts over 90 days may be referred to a collection agency.

I have read the above Acknowledgements and Agreements and fully understand the same.

Patient Name(print)____ **Date**__________________

Signature of Patient or Guardian__________________________________ **Relationship**________________

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We have developed our payment policy to address the questions we have received from our patients regarding patient and insurance responsibility for services rendered. Please read the policy, ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance-** We participate in most insurance plans, including Medicare. If you are not insured or insured by a plan that we do not participate with, payment is expected in full at time of service. If you are insured by a plan that we participate with but are unable to provide us with your current insurance coverage, payment is expected in full at time of service until we are provided your insurance information which we can verify. Knowing your insurance benefits is the responsibility of the patient. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and Deductibles-** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect your co-payment can be considered fraud. An additional $5.00 fee will be accessed to your account for not paying your co-pay at time of service.
3. **Non-covered Services-** Please be aware that some, perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of service.
4. **Proof of Insurance-** All patients must complete their patient information form before seeing the doctor. We must obtain a copy of your driver's license and current insurance card. If you fail to provide us with the correct insurance information in a timely matter, you may be responsible for the balance of the claim.
5. **Claims Submission-** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to the contract.
6. **Nonpayment-** If your account is over 90 days past due, you will receive a letter stating that you must pay for your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and an additional 28% surcharge will be added to your amount due for administrative fees that are incurred to us by the collection agency. The 28% is due to Brighton Family Physicians before any additional services are provided. A credit balance of $100.00 must then be maintained to continue services. You may also be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care, during these 30 days your physician will only treat you on an emergency basis.
7. **Missed Appointments-** Our Policy is to charge for missed appointments not cancelled within 24 hours. The $50 charge will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy

I have read and understand the payment policy and agree to abide by its terms:

Signature: ______________________________ **Date:** ________________________

Brighton Family Physicians, P.C.

Notice of Privacy Practices **Form 7.20**

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy of your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved In Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager, Joanne Sacco at:

Brighton Family Physicians 205 W. Grand River Avenue Suite 200 Brighton, MI 48116 (810)225-7773

Signature____ **Date**__________

Brighton Family Physicians, P.C.
Patient Authorization for Personal Representative
Please print then sign and date form at bottom.

Name of Practice: ***Brighton Family Physicians, P.C.***

Patient Name: ____

Date of Birth: ____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

____
Name of Personal Representative Phone

____
Address

____
City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

____

____

____

Attn: Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

____ ____________
patient signature date

Copies of signed authorizations are available upon request.