Ark Multispecialty Physicians, PLLC

Patient Registration

Today's Date:	Social Security #

PATIENT INFORMATION

Patient's last name: First:	Middle: [Initial]	Marital status: (circle one) Married, single, widow, divorced

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:

Home Phone#	Cell phone #	Email
Occupation:	Employer:	Employer phone no.:

How were you referred to our office? □ Doctor(name)_____ □ Insurance plan _____

□Relative/Friend _____ □ Web search (google, bing, etc.) _____ □ Other _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **ARK Multispecialty Physicians, PLLC** or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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Pharmacy Information	
Preferred Pharmacy	
Address	
Phone	
Fax	

Advanced Directives

☐ None ☐Do Not Resuscitate ☐Durable power of attorney (Date reviewed:_____) ☐ Living Will ☐HC Proxy

Medications- List all medication you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Allergies- List all known allergies (drugs, food, animals, etc.)

Medical History-Check if you have ever experienced the following conditions, and year of onset.

√	Condition	Year	√	Condition	Year
	Anemia			Hepatitis C	
	Angina			Hyperlipidemia	
	Anxiety			Hypertension	
	Arthritis			Irritable Bowel Disease	
	Asthma			Liver disease	
	Arterial fibrillation			Migraine Headache	
	Benign prostatic hypertrophy			Myocardial infection	
	Blood clots			Osteoarthritis	
	Cancer -type			Osteoporosis	
	Cerebrovascular Accident			Peptic ulcer Disease	
	Coronary artery disease			Renal Disease	
	COPD (Emphysema)			Seizure Disorder	
	Crohn's Disease			Thyroid Disease	
	Depression			Other	
	Diabetes			Other	
	Gallbladder disease				
	GERD (REFLEX)				

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Surgical History-Check if you have received the following procedures, and year performed					
Surgical procedure	Year		Surgical Procedure		Year
☐ None			MALE ONLY		
☐ Angioplasty		☐	Prostate Biopsy		
☐ Angioplasty w/stent		☐	Turp (Trans-urethral resection of prostate)		
☐ Appendectomy		☐	Vasectomy		
☐ Arthroscopy Knee		☐	Other		
☐ Back Surgery		☐	Other		
☐ CABG (Heart bypass)					
☐ Carpal Tunnel Release			Female Only		
☐ Cataract Extraction		☐	Augmentation mammoplasty		
☐ Cholecystectomy		☐	Bilateral tubal ligation		
☐ Colectomy		☐	Breast biopsy		
☐ Colostomy		☐	Cesarean section		
☐ Gastric Bypass		☐	D and C		
☐ Hernia Repair		☐	Hysterectomy		
☐ Hip Replacement		☐	Myomectomy		
☐ Knee Replacement		☐	Reduction Mammoplasty		
☐ Liver Biopsy		☐	TAH/BSO		
☐ Pacemaker		☐	VAGINAL HYSTERECTOMY		
☐ Small Bowel Resection		☐	OTHER		
☐ Thyroidectomy		☐	OTHER		
☐ Tonsillectomy		☐			

Health Maintenance-Check if you have received the following, and date of most recent exam.				
EXAM	DATE	EXAM		DATE
☐ None		☐	GYN Exam	
☐ Breast Exam		☐	Influenza Vaccine	
☐ Cardiac Stress Test		☐	Lipid Panel	
☐ Colonoscopy		☐	Mammogram	
☐ DEXA Scan		☐	PAP Test	
☐ Echocardiogram		☐	Physical exam	
☐ EKG		☐	Pneumococcal Vaccine	
☐ Eye Exam		☐	Pulmonary Function Test	
☐ FOOT EXAM		☐	Tetanus Vaccine	

Family History-Check if any family members(s) has had any of the following conditions.

☐ Adopted

DIAGNOSIS	MOTHER	FATHER	BROTHER	SISTER	OTHER	OTHER	OTHER
Alcoholism							
Alzheimer's Disease							
Asthma							
Blood Disease							
CAD (Heart Attack)							
Cancer-Type:							
CVA (Stroke)							
Depression							
Developmental Delay							
Diabetes							

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Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when service are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/responsible party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment of the condition which had brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative _____Date: _____

Printed Name of Patient or Personal Representative Patient _____

Ark Multispecialty Physicians, PLLC

Acknowledgement of Receipt
Joint Notice of Privacy Practices

Your name and signature on this form indicates that you received ***Joint Notice of Privacy Practices*** On the date indicated below.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date Received : _____

For Facility use Only

We attempted to obtain written acknowledgement of patient's receipt of our ***Joint Notice of Privacy Practices***, but acknowledgement could not be obtained from the patient for the following reason:

- ☐ Individual refused to sign
- ☐ Emergency Situation prevented signature
- ☐ Patient requested above individual sign on his/her behalf
- ☐ Other (please specify)

  _____

Registration Representative Signature: _____ Date:

Acknowledgement of Receipt **Joint Notice of Privacy Practices**	**Ark Multispecialty Physicians, PLLC** **25130 Southfield Rd, Suite 105** **Southfield, MI 48075** **Phone: 248-234-6790 Fax: 248-595-8586**