NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.

PATIENT INFORMATION FORM

Please read & complete all necessary information accurately

PATIENT INFORMATION

Name:_____ Date of Birth_____

Address: _____ City: _____ St. _____ Zip:_____

Hm phone: _____ Wk phone: _____ Cell #: _____

Patient's place of employment: _____ Phone# _____

Social Security # _____ Single _____ Married _____ Divorced_____ Other_____

Spouse or Guardian Name: _____ Phone #_____

If patient is under 18 years of age, who is responsible for this bill? _____

What is their address: _____

What is their phone #: _____ Date of Birth_____ Relationship to patient_____

PRIMARY INSURANCE

Insurance Carrier: _____

Group #: _____ Contract ID #: _____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____ Phone # (if different than patients) _____

Address (if different than patients): _____

Relationship to patient: Self _____ Spouse _____ Parent _____ Legal Guardian _____ Other _____

Subscriber's Employer: _____

Employer's Phone #: _____

SECONDARY INSURANCE

Insurance Carrier: _____

Group #: _____ Contract ID #: _____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____ Phone # (if different than patients) _____

Address (if different than patients): _____

Relationship to patient: Self _____ Spouse _____ Parent _____ Legal Guardian _____

Subscriber's Employer: _____

Employer's Phone #: _____

EMERGENCY CONTACT

Whom may we contact in case of an emergency?

Name: _____ Phone #: _____

Relationship to patient: _____

Nearest relative not living with you: _____ Phone#: _____

Nearest friend not living with you: _____ Phone #: _____

FINANCIAL RESPONSIBILITY

I understand that and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date:_____

(parents signature if patient is a minor)

NORTH MACOMB MEDCIAL ASSOCIATES, P.L.L.C.

Please read & complete all necessary information accurately

PATIENT HISTORY (CHILD)

Patient Name: _____Date of Birth _____

Sex: □ Male □ Female

BIRTH HISTORY

Birth Weight: _____Length: _____Type of Delivery: □ Vaginal r C-section: reason for C-section _____

Baby was: □ _____ Early days/wks □ On time □ Late Hospital _____

Any complications with pregnancy? □ Yes □ No if yes, explain_____

_____

Any problems with baby in nursery? □ Yes □ No if yes, explain_____

_____

Circumcised? □ Yes □ No Received first Hep B vaccine? □ Yes □ No

MEDICAL HISTORY

Health Problems: _____

Hospitalizations (date & reason): _____

_____

Surgeries (date & reason): _____

_____

Has the child ever had a history of any of the following? (give approximate age at onset)

chicken pox_____	scarlet fever_____	□asthma _____
seizures _____	rheumatic fever _____	□ heart murmur _____
ear infections _____	pneumonia _____	□ allergies _____

Medications: _____

_____

Allergies to medications: _____

FAMILY HISTORY

Mothers age: _____Health problems:_____

Fathers age: _____ Health problems: _____

Brothers and sisters names: age sex health problems

_____

_____

_____

NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.

PAYMENT POLICY

PLEASE READ CAREFULLY BEFORE SIGNING

I authorize payment directly to Dr. Frocillo, Dr. Plumer-Haun, Dr. McCowan, Dr. Stratford, Dr. Bulica, Deborah Berry PA-C, & Sarah Weymouth PA-C for surgical and/or medical services as described, but not to exceed reasonable and customary charges for those services. I authorize the above doctors to release any information acquired in the course of my treatment necessary to determine those benefits.

OUR POLICY IS PAYMENT AT THE TIME OF SERVICE. All applicable **copays, deductibles, and outstanding balances must be paid in full at the time of your visit**. Payment may be made by cash, check, or credit card.

It is understood that NMMA will bill the insurance company that I provide them with as a courtesy to me, and that a secondary insurance will also be billed if applicable. Please understand that this is not a guarantee of insurance benefits. Any questions you may have regarding insurance coverage should be directed to your insurer. I also understand that in the event that I do not provide current information to NMMA it is my responsibility to pay any outstanding balances to the office directly.

- I understand that I am responsible for the payment of any charges that are not covered by my insurance company and for charges resulting from deductibles or co-pays required by my insurance company. I understand that my payment responsibility extends to all those covered under my policy, regardless of age, relationship, or living arrangements unless otherwise specified.

- The parent accompanying a minor child is responsible for any and all charges incurred. We can not and will not bill the other parent.

- In the event that the amount owed can not be determined until after insurance billing, a statement will be forwarded to you. Payment in full is expected upon receipt of this statement. Accounts that reach a past due status (any balance over 30 days old) will be assessed a late fee. Any accounts with a past due amount exceeding 90 days or more may be referred to a collection agency for further collection action.

- I understand that a fee will be assessed for the completion of forms, including disability forms, FMLA, employer communications and sports physicals.

- I understand that a fee may be assessed for emergency phone consultations with physicians after regular office hours, and that any such fees not covered by my insurance carrier will be applied to my account.

We make every attempt to have patients scheduled and seen by their physician in a timely manner. For this reason, a 24 hour notice is required for all appointment cancellations, otherwise a $20 “NO-SHOW” fee will be applied to your account.

Signature of patient (if minor, parents signature)_____

Date:_____ Witness Initials:_____

NORTH MACOMB MEDICAL ASSOCIATES, P.L.L.C.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES, containing a more complete description of the users and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact the organization at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relaying on this acknowledgment.

Patient Name:_____
Signature: _____ Date:_____

If Personal Representative's signature appears above, describe Personal Representative's relationship to the patient: _____.

The patient presented for treatment on this date and was provided with this acknowledgment for our NOTICE OF PRIVACY PRACTICES. A good faith effort was made to obtain a written acknowledgment of receipt of the notice. However, an acknowledgment was not obtained because:

☐ Patient refused to sign
☐ Patient was unable to sign because _____
☐ There was a medical emergency (the practice will attempt to obtain acknowledgment at the next available opportunity.

Signature of employee witnessing and/or completing form: _____

Vaccine Administration Record for Children and Teens

Patient name: _____

Birthdate: _____

Chart number: _____

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.									
Diphtheria, Tetanus, Pertussis[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, DTaP-Hib-IPV, Tdap, DTaP-IPV, Td) Give IM.									
***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib-IPV, DTaP-Hib) Give IM.									
Polio[5] (e.g., IPV, DTaP-HepB-IPV, DTaP-Hib-IPV, DTaP-IPV) Give IPV SC or IM. Give all others IM.									
Pneumococcal (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM.									
Rotavirus (Rota) Give oral (po).									
Measles, Mumps, Rubella[5] (e.g., MMR, MMRV) Give SC.									
Varicella[5] (e.g., Var, MMRV) Give SC.									
Hepatitis A (HepA) Give IM.									
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.									
Human papillomavirus (e.g., HPV) Give IM.									
Influenza[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN.									
Other									

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or po (by mouth).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

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www.immunize.org/catg.d/p2022.pdf • Item #P2022 (2/08)

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