



Pediatric Patient Registration Form

Patient Last Name:		Patient First Name:	
SSN	DOB	Age	Gender
Address			
City		Zip	Cell Phone
Home Phone		Work Phone	
How did you hear of us?		Spouse Still Working?	
Emergency Contact Person		Emergency Contact Phone Number	
Insured's Name		Relation to patient	
Insured's Work Phone		Insured's Home Phone	
SSN:	DOB	Age	Gender

IF YOU'RE HERE AS A RESULT OF AN INJURY, PLEASE COMPLETE THE FOLLOWING:

Date Occurred	How it occurred		
Insurance Name	Claim #		
Address			
City	State	Zip	Phone ()

WHERE WOULD YOU LIKE YOUR PRESCRIPTIONS SENT?

Local Pharmacy : (List Name/Location/City/Phone)	
Mail Order Pharmacy:	

OPTIONAL

Some third party payers (HAP/BCN) are now requiring that we provide them with our patient's Race and Ethnicity. They are using this information to track and achieve measurable reductions in racial/ethnic disparities in healthcare.

Check here if you do not want to provide this information

Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other
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ASSIGNMENT OF BENEFITS/AUTHORIZATION

I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM FORMS. IN ADDITION, I REQUEST CLAIMS BE SUBMITTED ON MY BEHALF AND PAYMENT FOR SERVICES RENDERED BE DIRECTLY MADE TO EPIC PRIMARY CARE, PLLC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR AMOUNTS APPLIED TO INSURANCE POLICY DEDUCTIBLES AND CO-PAYMENTS NOT COVERED BY MY INSURANCE COMPANY.

PATIENT/GUARDIAN SIGNATURE _____ DATE: _____

Name: _____
Last First Initial

Birth Date: _____

Address: _____
Number Street City Zip Code

MEDICAL HISTORY						DOCTORS USE ONLY		
FAMILY	Have any members of your family (parents, brothers, sisters, grandparents, aunts, uncles) ever had:					COMMENTS:		
		YES	NO		YES			NO
	High blood pressure			Cancer				
	Heart Trouble			Asthma				
	Diabetes			Mental disorders				
	Arthritis			Other				
BIRTH & DEVELOPMENT	Tuberculosis							
	Term _____ Delivery _____ Birth Weight _____							
	Condition at Birth _____							
	Condition 1st Week _____							
	Feeding _____ Cyanosis _____							
	Convulsions _____ Jaundice _____							
	Sat Up _____ Stood _____ Walked _____ Words _____							
	Short Sentences _____ First Teeth _____ Bladder _____ Bowel _____							
PERSONAL - PAST	Has your child ever had:					YES	NO	
		YES	NO		YES	NO		
	Measles			Epilepsy				
	Mumps			Ear Infections				
	Whooping cough			Hepatitis				
	Chicken pox			Diabetes				
	Scarlet fever			Kidney Trouble				
	Asthma			Concussion				
	Tuberculosis			Heart Murmur				
	Mental Disorders			Hernia				
	Rheumatic fever			Surgery				
	Allergic disease			Hospitalization for illness or injury				
	Does your child:			Use drugs				
	Smoke			Drink alcohol				
	Was your child ever treated for:			Skin irritation				
Fracture or Dislocation			Behavior problem					
Bone infection or disease								

*List any allergies to medications: _____

Physician Signature: _____



Pediatric Review of Body System
(Patient/Guardian to fill out for child)

HEART (CARDIOVASCULAR SYSTEM)

	chest pain
	loss of consciousness

PATIENT NAME: _____

	difficulty breathing while laying down

LUNGS (PULMONARY SYSTEM)

	cough
	difficulty breathing

	wheezing
	chronic cough (longer than one month)

BOWELS (GASTROINTESTINAL SYSTEM)

	abdominal pain
	change in bowel habits
	constipation

	bright red or maroon stools
	nausea

	vomiting
	diarrhea

NERVOUS (NEUROLOGICAL SYSTEM)

	difficulty speaking
	difficulty walking
	weakness

	headaches (other)
	seizures

	loss of coordination
	visual changes

MUSCULOSKELETAL (MUSCLE & BONE) SYSTEM

	joint redness
	joint swelling

	joint pain

	muscle ache

URINARY TRACT SYSTEM

	urinating frequently
	awakening frequently to urinate

	urinating blood
	urinary leakage

	painful urination
	weak urine stream

EAR, NOSE, AND THROAT

	runny nose
	nose bleeds
	nasal congestion
	snoring

	red eyes
	itchy/watery eyes
	excessive sneezing
	ear aches

	sore throats
	bad breath
	enlarged tonsils

SKIN (DERMATOLOGY)

	rash
	new skin lesion
	keloid/scar formation

	dark moles
	easy bruising
	loss of pigment

	slow healing cuts
	loss of hair

GYNECOLOGIC/UROLOGIC

	painful menstruation
	breast mass/lump
	vaginal discharge

	change in menstruation
	nipple discharge
	testicular pain

	breast tenderness
	testicular mass

PSYCHIATRY

	depression
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	anxiety state
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	obsessive/compulsive
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ENDOCRINE/GLANDULAR SYSTEM

	weight gain
	increased appetite
	fatigue

	weight loss
	tremors/shaky
	increased perspiration

	increased thirst
	excessive hair growth

Parent/Guardian Signature: _____

Date: _____

Reviewed By: _____

Date: _____



PATIENT NAME: _____ DOB: _____

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

I, _____ (patient name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Name of Personal Representative

The authority of this person when acting as my personal representative is restricted to the following functions: _____

Description: _____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to EPIC Primary Care, PLLC. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Signature _____ Date _____

REVOCATION SECTION

I hereby revoke this designation of a personal representative.

Signature: _____ Date: _____



PATIENT NAME: _____ DOB: _____

This is an agreement between EPIC Primary Care, PLLC, a Michigan Professional Limited Liability Company, located at 911 E 9 Mile Rd, Ferndale, MI 48220 and _____ (hereinafter referred to as "Patient") located at _____ In this agreement the words "you," "your," and "yours" mean the Patient.

The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to EPIC Primary Care, PLLC.

By executing this agreement, you agree to pay for all services that are received as well as the following and subject to all of the terms and conditions set forth herein.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Paper Statement sent to home

Secure Electronic Statement sent via e-mail address: _____ @ _____ . _____

Payment options:

1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. You may pay online via our patient payment portal.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service, in full.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay such co-pay or deductible at the time service is rendered. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Your Insurance policy is a contract between you and your insurance company. If we are NOT a party to this contract, we will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

After Hours Fee: There is an Evening/Weekend/Holiday surcharge of \$24 that is for services provided after 5:00 PM, on a weekend, or on a federal or state holiday.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of point zero five percent (.05%) per month or an **ANNUAL PERCENTAGE RATE** of six (6%) percent. The finance charge on your account is computed by applying the periodic rate (.05%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$.50.

Returned checks: There is a \$35 fee for any checks returned by the bank.

Statement Fee: A billing fee of \$10 will be imposed on each statement that is sent to Patient due to Patient's non-payment on the date of service. After the fourth consecutive statement with no Patient response, we will no longer be able to see you in our office, and you may be sent to collections. **PAGE 1 OF 2**

Credit History: We reserve the right to report your account status to any credit reporting agency such as a credit bureau.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these, as it is against our contract for us not to collect co-payment for our services rendered. Any payment made on the account will be applied to the oldest balance first.

Missed appointment: Patients with three missed appointments may be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take any legal steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all actual lawyers' fees which we incur plus all court costs and other charges. In case of suit, you agree that such venue shall be the courts in Oakland County, Michigan.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay up to a \$125 fee, if you want to pick up a copy of your records. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Master Medical: If you have master medical, you will be required to pay all of your office visit fees at the time of service. We will bill BCBS as a courtesy to you in order for you to be reimbursed by the carrier.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Disputed Charges: We kindly request that you immediately question any disputed charges with our billing department before contacting your insurance company.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____
(Print)

Responsible Party: _____
(If not the patient)

Patient Signature: _____ Date: _____

Co-Signature: _____ Date: _____



EPIC Primary Care has been a member of the Electronic Prescribing Initiative (E-prescribe) since 2002. The goal of the **E-prescribe** Initiative is to improve the safety, quality and cost-effectiveness of the prescription process. It has been a struggle because many pharmacies were not registered or equipped to perform this bidirectional communication. Thankfully, in July 2008, the federal government implemented the Medicare Improvements for Patients and Providers Act (MIPPA) as an initial step towards mandating e-Prescribing technology. Since this time there has been much progress in the industry to comply with these standards. To act in accordance with these initiatives we need to collect additional information from each of our patients.

For our patients who use chronic prescription medications (diabetic or heart medications, etc.) it will no longer be necessary to call our office to request a refill. You can now request a refill online through our My EPIC Chart patient portal. If you do not have access to the internet or an e-mail address you will need to call your pharmacist and request that they **“submit an e-refill request to my doctor”**. Your pharmacist will know what this means.

We are excited at the success of our My EPIC Chart portal. You can sign up at www.epicpc.com. This portal allows you to send secure messages to your doctor and schedule appointments. You can use the portal 24/7 and not have to wait for the office to open to make your requests. Our portal is designed to be very secure and HIPAA compliant.

PLEASE REMEMBER THAT **EPIC PRIMARY CARE** WILL CONTINUE TO WORK HARD TO GIVE THE BEST CARE TO OUR PATIENTS. WE WILL CONTINUE TO STRIVE TO INTEGRATE ALL THE NEWEST AND LATEST ADVANCEMENTS IN THE MEDICAL INDUSTRY.

Please provide your current e-mail address as well as your preferred pharmacies. Please verify your contact information as well. *If you have already filled this out please inform the Medical Receptionist.* **Please note this form should be filled out for all of our patients including family members who are old enough to have an email address or will likely require long term medications.**

Name: _____	DOB: _____
Address: _____	Home Phone: _____
City, ST: _____	Work Phone: _____
ZIP: _____	Cell Phone: _____

Email: _____

Local Pharmacy (list name/location/city/phone):

Mail Order Pharmacy:



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize EPIC Primary Care, PLLC, It's Director or designee, or Medical Information Services Department to release information contained in my patient records, including alcohol and drug abuse records, protected under the regulations in 42 Code of Federal Regulations, Part 2, if any psychiatric psychological services records, if any, and social work, records, if any, including communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any to the individuals or organizations listed below, only under the conditions listed below:

Patients Phone Number: _____

Birth date of Patient: _____ Patient Name: _____

1. Name of person or organization to which disclosure is to be made:

- Allscripts Community Exchange

2. Specific type of information to be disclosed: All records as well as allow EPIC PRIMARY CARE to request records from previous clinicians as needed for continuation of care.

3. The purpose and need for such disclosure: Continuation of Treatment or Health Care

Signature (patient or parent/guardian)

Date



A Patient-Centered Medical Home is a Partnership between the Patient and Their Physician

By choosing to participate in a Patient-Centered Medical Home, I agree to:

- Make sure my doctor knows my entire medical history
- Tell my doctor all of the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Adhere to the action plan designed by my doctors
- Consult my doctor before making my own appointment with a Specialist
- Request that any other doctor I see send my doctor a report, copies of lab work, test results, and x-rays
- Know my insurance and what it covers
- Provide the office feedback on how they can improve their services

Being a part of a Patient-Centered Medical Home, your doctor will:

- Work with you to improve your health
- Review your medications at every visit and discuss with you any interactions or contraindications
- Electronically prescribe your medications to ensure they are accurate and available to you promptly
- Develop a personal action plan with you to address your chronic conditions
- Set goals with you and monitor your progress
- Use computer technology to monitor your progress and determine if your health is improving
- Inform you of all test results
- Help you take control of your health by providing you educational material, hosting group visits and linking you to other community programs and resources
- Provide you 24 hour access to a clinical decision-maker by phone
- Have arrangements with after-hours care to be informed of your visit or emergent treatment within 24 hours or next business day
- Reserve space in our schedule for you to accommodate a same-day appointment

Patient Name: _____

Signature: _____

Date: _____

PCMH: EPIC Primary Care, PLLC _____

Signature: _____

Date: _____