PATIENT INFORMATION

Last Name ____________________ First Name ____________________ Middle Initial ________

SS# ____________________ Sex ____________ Date of Birth ____________

Aliases (Maiden name, nickname) ____________________ Advance Directive Yes / No

Street Address ____________________ City/Zip Code ____________________

Home Phone ____________ Work Phone ____________ Cell ____________

Maritial Status ____________________ Email Address ____________________

Ethnicity ____________ Race ____________ Preferred Language ____________

Emergency Contact

Emergency Contact ____________________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Cell ____________

Emergency Contact ____________________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Cell ____________

Patient Employer Information

Employer ____________________ Employment Status Full Time/ Part Time

Employer Address & Phone # ____

Insurance Coverage

Benefit Plan ____________ Subscriber ID#____________ Group # ____________

Subscriber Name ____________________ Relationship to Subscriber ____________

Subscriber SS# ____________________ Subscriber Date of Birth ____________

Employer Name, Address & Phone # ____

Insurance Coverage - Secondary

Benefit Plan ____________ Subscriber ID# ____________ Group # ____________

Subscriber Name ____________________ Relationship to Subscriber ____________

Subscriber SS# ____________________ Subscriber Date of Birth ____________

Employer Name, Address & Phone # ____

Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage with ______________________________
Name of Insurance Company

and assign directly to **South Lyon Family Docs** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the insurance carrier mentioned above terminates.

______________________________ ______________________________
Signature of Patient, Guardian or Personal Representative **Date**

______________________________ ______________________________
Print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

Release of Patient Information

Do you wish to authorize the release of your medical information to another specified individual(s), such as Spouse, Parent, Guardian, Partner, etc. ☐ **Yes** ☐ **No**

______________________________ ______________________________
Name of Individual to which information may be released **Relationship to Patient**

______________________________ ______________________________
Name of Individual to which information may be released **Relationship to Patient**

______________________________ ______________________________
Name of Individual to which information may be released **Relationship to Patient**

______________________________ ______________________________
Name of Individual to which information may be released **Relationship to Patient**

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

Advance Directive

Do you have an Advance Directive? ☐ **Yes** ☐ **No**

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

*If yes, we would appreciate it if you would provide us with a copy of your medical record.

**Brochure is available upon request.

South Lyon Family Docs

GENERAL CONSENT TO TREATMENT

Patient Name: ____

Date of Birth: ________________________ **Medical Record #** ________________

1. **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include: diagnostic; radiology and laboratory procedures; blood transfusions; anesthesia; therapeutic procedures; drugs; and medical; nursing and hospital care.

2. **Release of Information:** I authorize South Lyon Family Docs to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information my include Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records, and social work records, if any.

3. **Human Immunodeficiency Virus (HIV) and Hepatitis B/C Testing:** I understand and agree that, in accordance with State law, an HIV, HBV or HCV test may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of any test will be treated confidentially.

4. **Testing and Disposal of Specimens and Tissues:** I authorize South Lyon Family Docs to retain, preserve or use for research scientific or teaching purposes, or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

5. **Valuables:** I release South Lyon Family Docs from responsibility of all personal articles which I have with me during the time I am a patient at the office. I understand that the office is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession or in the office.

6. **Payment:** I assign and authorize payment from my insurance company directly to South Lyon Family Docs for any and all services rendered. I agree to pay, at the time of discharge or on an interim basis (agreed upon by the office), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay South Lyon Family Docs all charges for services rendered irrespective of any disputes or disagreements between myself and insurance companies.

7. **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

8. **Minors:** A patient under 18 years of age must have authorization of treatment from a parent or legal guardian. Minors with decision-making capacity have the right to participate in discussions regarding their care, and to answers to their questions about their condition and treatment.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

____

Date *Signature of patient/parent (if patient is a minor/legal guardian) relative (if patient is unable to consent)*

____

Signature of Witness *Please indicate relationship*

South Lyon Family Docs

PATIENT AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

I ____, hereby authorize

Person/Organization to Release Information ____________________________

Address ____

Phone/Fax Number ____________________________________

to release information contained in my patient medical record INCLUDING alcohol and drug abuse records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any, psychiatric, psychological service records, if any, and social work records. If any, including communications made by me to a social workers psychiatrist/psychologist, and any information regarding 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 individuals or organizations listed below under the conditions listed below:

1. Person to Whom Disclosure is to be made: **SOUTH LYON FAMILY DOCS**

   Address: **26006 Pontiac Trail, South Lyon MI 48178** Fax Number: **248-437-5694**

2. DO NOT DISCLOSE THE FOLLOWING (Check all that apply) ☐ Alcohol and/or Drug Abuse Information
   ☐ HIV, AIDS, or ARC Information ☐ Psychiatric Information

3. ____

   SPECIFIC AND MEANINGFUL DESCRIPTION OF THE INFORMATION TO BE DISCLOSED – INCLUDE DATES

4. The purpose and need for such disclosure: ☐ CONTINUATION OF TREATMENT/FOLLOW-UP
   ☐ BILLING INFORMATION/INSURANCE ☐ PER THE REQUEST OF THE INDIVIDUAL
   ☐ OTHER (specify) ____________________________________

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing.

I understand that my health information that is disclosed under this Authorization may be subject to redisclosure by the recipient and the privacy of my health information will no longer be protected by the law.

Signature(s): ____________________________________ Date: ________________
Patient

____________________ ____________________ ____________________
Driver's License Number Date of Birth of Patient Last four digits of SSN

____________________________________ Date: ________________
Parent/Guardian /Legal Representative

____
Driver's License Number

Legal Representative Paperwork: ☐ Proof of Guardianship ☐ Durable Power of Attorney for Healthcare
(attach a copy) ☐ Letters of Authority

Witness Signature: ____________________________________ Date: ________________