21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

REGISTRATION FORM

Today's Date____/____/ _____ **Please Print** **PCP_________________________________**

PATIENT INFORMATION

Patient's Last Name First Middle	___ Mr. ___Miss ___ Mrs. ___Ms.	Marital Status /Race ___Single ___ Married ___Widowed ___Separated ___Divorced ___ White ___Blk ___Other

Is this your legal name ____Yes ____No	If not, what is your legal name	(Former Name)	Sex ___Male ___Female

Birth Date _____/ ______/ ______	Age	Social Security # __ __ __ / __ __/ __ __ __ __	Home Phone No. ( )	Cell Phone No. ( )

Street Address	City	State	ZIP Code

Occupation	Employer	(Employer Phone No) ( )

Chose clinic Because/Referred to Clinic by (Please check one) ___Dr. ________________________
___Insurance Plan ___ Hospital ___ Family ___ Friend ___ Close to home/ work ___Yellow Pages __ Other_____________________

Family Members seen here____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date ____/ _____/ ______	Address (If different)	Home Tel: ( )
Is this person a patient here? ___ Yes ___ No			
Occupation	Employer	Employer Address	Employer phone No. ( )

Is this patient covered by insurance? ___ Yes ___ No

Please indicate primary insurance ___ **BCBS** ____**BCN** ____ **MEDICARE** ___ **MEDICAID** ___ **PPOM** ___ **DMC CARE**
____ **AETNA** ___ **HAP** ____ **OMNI CARE** ____ **HUMANA** **Other**________________________________

Subscriber's Name	Subscriber's S.S. # __ __ __ / __ __/ __ __ __ __	Birth Date _____/ ____/ _____
Group#	Policy #	Co-Payment $

Patient's Relationship to Subscriber __ Self ___Spouse ___ Child __Other

Secondary Insurance (if Applicable)	Subscriber's S.S. # __ __ __ / __ __/ __ __ __ __	Birth Date _____/ ____/ _____
Group#	Policy #	Co-Payment $

Patient's Relationship to Subscriber __ Self ___Spouse ___ Child __Other

IN CASE OF EMARGENCEY

Name of Local Friend or Relative (not living at same address)	Relationship to patient	Home phone#	Work Phone #

The above information is true to the best of my knowledge. **I UNDERSTAND AND THAT I AM FINACIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.** I also authorize the insurance company to release any information required to process my claims.

X____ X_______________________
PATIENT/GUARDIAN SIGNATURE **DATE**

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

KNOW YOUR BENEFITS

This list defines many common healthcare terms you might not know. Knowing these terms can help you choose a plan that meets your needs. Some of these words are common with many types of insurance. The following common health term explains what the words and phrases mean for health insurance.

- **CO-PAY:** Your co-pay is usually a percent amount such as $10.00, $20.00, 20% etc. That is determined by your insurance company according to your contract with them. This amount is known at the time of service and is to be paid at the time of service.
- **DEDUCTIBLE** Your deductible is determined by your contract with the insurance company. It is your responsibility to know your yearly deductible and be prepared to pay the amount when billed. If you have two insurance (like Medicare and Blue Cross) you may have two deductibles to satisfy each year. This amount is known after the insurance company is billed and responds. The explanation of Benefits that you receive at your home reflects the amounts, if any, that was applied to your deductible. This amount is your responsibility.
- **CO-INSURANCE:** is a percentage of an approved amount owed to a provider for a covered service. Some contracts have co-insurance responsibilities. It is usually 10% of all services billed. This amount is known after the insurance company is billed and responds
- **COST-SHARING:** A patient's co-pay and co-insurance determined by their insurance company according to their contract.
- **EXPLANATION OF BENEFITS:** When your insurance is billed, you receive an "Explanation of Benefits" in the mail. This also says, "This is not a Bill". If you read these, they will tell you what you may owe to a doctor. You can also keep track of what was paid/owed on your yearly deductible. Keep a record of these and you will know if you receive a bill in error or if you need to expect a bill from a provider.

We hope these definitions help you to understand your financial responsibilities to your health care providers. If you would like further explanation of your statements, leave your name, and call back number with the office and billing department will get back with you.

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

PRIVACY PRACTICES

The purpose of privacy practice of notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We are ethically and legally required to maintain the privacy of protected health information. We must provide individuals with notice of our legal duties and privacy policies with respect to protected health information. We must abide by the terms of our notice of Privacy Practices currently in effect. We reserve the right to change our privacy practices that are described in the notice. We will post any revised notice in the waiting area and you may obtain a revised notice by forwarding a written request to our office.

With your consent, we may use and disclose protected health information about you to carry out treatment, payment, or healthcare operation. Treatment means the provision of healthcare and related services by one or more healthcare providers. For example, we may disclose protected health information to nurses providing healthcare under our direction. Payment means the activities we do to obtain reimbursement for the provision of healthcare. For example, your health insurer pays for the services. Healthcare operations include many oversight functions, such as quality assessment, credentialing, and business management. For example, we may disclose protected health information to licensing officials obtaining or renewing our professional licenses.

We may use or disclose protected health information without your written consent or authorization for certain national priority purposes. The following is a brief description of these national priority purposes:

- Required by law
- Person subject to Food and Drug Admin
- Employer relating to workplace: work-related illness
- Health oversight agencies
- Subpoena, discovery request
- Coroners and medical examiners
- Organ donor purposes
- Avert serious treat to health
- National Security and Intelligence
- Medical suitability determinations
- Eligibility for public benefits
- Public Health Authority

We may use or disclose protected health information without your written consent or authorization for certain purpose unless you object. The following is a brief description of these purposes for which you have an opportunity to object:

- Directory of individuals in facility, limited to name, location in facility, condition in general terms, and religious affiliation
- Family members and person responsible for care
- Disaster relief purposes.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Except as otherwise stated in our Notice of Privacy Practices, we will use and disclose your protected health information with your written authorization, and you may revoke such authorization at any time.
You have the following rights with respect to your protected health information:

- The right to request restriction on certain uses and disclosures of protected health information, but we are not required to agree to your requested restrictions.
- The right to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy protected health information, subject to changes for the costs of copying, mailing, or other supplies/costs associated with your request.
- The right to amend protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this Notice of Privacy Practices, if this notice was furnished electronically.

You may exercise any of these rights by forwarding a written request to our office. If you request an amendment to protected health information, you must also include a written reason to support the requested amendment.

You may complain to us or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, you must forward a written statement describing the act or omissions believed to be in violation of your rights to the address it shown below. We will not retaliate.

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

No-Show, Late, & Cancellation Policy

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. The Grace Endocrine Service's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. **Established patients:**
   a. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time.
   b. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens.
   c. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from the Grace Endocrine Services. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with Grace Endocrine Services guidelines.

III. **New patients:**
   a. Appointment must be cancelled at least 24 hours prior to scheduled appointment time.
   b. In the event of a no-show, the Grace Endocrine Services may require a new referral sent from the referring physician.
   c. In the event a patient arrives late as defined by "late arrival" to their appointment, the Grace Endocrine Services reserves the right to request a new referral sent from the referring physician.
   d. In the event of three (3) documented "same-day cancellations," the patient may be subject to dismissal from the Grace Endocrine Services. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with Grace Endocrine Services guidelines.

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

Visitor Information Form

For your safety and privacy, we are required to ask you about your preferences for anyone who joins you in the examination room.

Patient Name ____ Date _____________________

1. Do you want to have someone with you in the exam room today? ___ YES ___NO
2. Name of Visitor ____
3. Relationship ____
4. Reason ____
5. Would you want us to discuss your personal health information with this person present?

   ___ YES ___NO
6. Do you want them to be asked to leave at any point in the appointment?
   (We routinely ask visitors to leave during a physical examination.) ___ YES ___NO
7. With whom may we share your personal health information?

   ___ Only myself ____

   ___ Myself and ____

I have read (or had read to me) and fully understand the above information, as described above.

Patients Signature: ___________________________________ Date: ____________________

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

No-Show, Late, & Cancellation Policy

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. The Grace Endocrine Service's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. **Established patients:**
   a. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time.
   b. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens.
   c. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from the Grace Endocrine Services. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with Grace Endocrine Services guidelines.

III. **New patients:**
   a. Appointment must be cancelled at least 24 hours prior to scheduled appointment time.
   b. In the event of a no-show, the Grace Endocrine Services may require a new referral sent from the referring physician.
   c. In the event a patient arrives late as defined by "late arrival" to their appointment, the Grace Endocrine Services reserves the right to request a new referral sent from the referring physician.
   d. In the event of three (3) documented "same-day cancellations," the patient may be subject to dismissal from the Grace Endocrine Services. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with Grace Endocrine Services guidelines.

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

Telehealth Consent Form

Health Care Services

1. I hereby authorize Health Care Services to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.
6. Patients can withhold or withdraw their consent to the Telemedicine Consultation at any time and it is guaranteed by laws that any action will not affect further treatment.

_____________________________ ___________________ ____________________

Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

_____________________________ ___________________ __________ ___________________

Name of Guardian/ Legal Relationship Date Representative

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

Visitor Information Form

For your safety and privacy, we are required to ask you about your preferences for anyone who joins you in the examination room.

Patient Name ____ Date _____________________

1. Do you want to have someone with you in the exam room today? ___ YES ___NO
2. Name of Visitor ____
3. Relationship ____
4. Reason ____
5. Would you want us to discuss your personal health information with this person present?

   ___ YES ___NO
6. Do you want them to be asked to leave at any point in the appointment?
   (We routinely ask visitors to leave during a physical examination.) ___ YES ___NO
7. With whom may we share your personal health information?

   ___ Only myself ____

   ___ Myself and ____

I have read (or had read to me) and fully understand the above information, as described above.

Patients Signature: ___________________________________ Date: ____________________

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

Medication Sheet

Patient Name: ____ Date ____________

Allergies:____

Pharmacy Number: ____

Date Start	Date Stop	List of Medication	Dosage	Amount	Refills		
					Date	Amount	Initials

21510 Harrington Street, Suite 303
Clinton Township MI 48036
Phone:(586) 741-5346
Fax: (586) 741-8886

GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

FINANCIAL AGREEMENT **PATIENT NAME: ___________________________________**

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. Patient payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. Forms: There is a $15 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed. There is also a $5 fee for any forms that need to be faxed instead of mailed.

4. Registration: All patients must complete patient registration information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

5. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

6. Uninsured patients: We offer a discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action. **If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangement**

7. Credit and collection: If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at that time be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period our physicians will be able to treat you only on an emergency basis.

8. Phone management fee: There will be a charge for managing and treating a minor acute illness (e.g., cold, flu, or sinus congestion) over the phone. The phone management fee will not be billed to your insurance and is your full responsibility.

9. Missed appointments: Our policy is to charge $25 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X SIGNATURE OF PATIENT OR RESPONSIBLE PARTY ____Date_____________________