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GRACE ENDOCRINE SERVICES
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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 Is this person a patient here? ___ Yes ___ No	Birth Date ____/ _____/ _____	Address (If different)	Home Tel: ( )
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**

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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.

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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_____

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FINANCIAL POLICY

Patient Name: _____Date of Birth: _____

BASIC POLICY: Payment for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE: We bill most insurance carries for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid with 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you.
All co-payments or deductibles are due and payable at the time service is provided.

MEDICAID PATIENTS: All Medicaid patients must provide a current insurance card & valid ID card before being seen.

NON-COVERD SERVICE: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MISSED APPOINTMENTS: In fairness to other patients, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments.

Please check one: I have paid my insurance deductible for the calendar years _____ ____Yes ____No ___ Do not know

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the CMS and its agents my information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 11 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. On Medicare assigned cases, the provider or supplier agree to accept the charge determination of the Medicare carrier as the all charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print):	**PROVIDER**
Patient's Signature:	
Patient's Medicare No: _____ Date_____	

ASSIGNMENT OF INSURANCE BENEFITS: Patients please read and sign below. I hereby assign all medical to which I am entitled, private insurance, and any other health plans, to **Grace Endocrine Services, PLLC** This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

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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.

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Patient Rights & Responsibilities - Michigan

Federal laws and regulations govern many aspects of the health care system. In Michigan, state laws provide some additional protection. Even these laws do not go far enough, because a patient cannot file a legal claim to protect his or her rights, before suffering serious physical injury.

The Michigan law, **MCL 333.20201**, known as the Patient Bill of Rights provides that a patient or resident of a health care facility have, at a minimum, the following rights.

A patient or resident has the RIGHT:

- To not be denied appropriate care based on race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.
- To inspect, or receive for a reasonable fee, a copy of his or her medical record upon request. A third party shall not be given a copy of the person's medical record without prior authorization of that individual.
- To confidential treatment of personal and medical records.
- To refuse release of personal and medical records to a person outside the health facility or agency, except as required because of a transfer to another health care facility or as required by law or third-party payment contract.
- To privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.
- To receive adequate and appropriate care.
- To receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contradicted as documented by the attending physician in the medical record.
- To refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. If a refusal of treatment prevents a health facility or agency or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice.
- To exercise his or her rights as a patient or resident and as a citizen, and present grievances or recommend changes in policies and services on behalf of himself or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal.
- To receive information about the health facility's or agency's policies and procedures for initiation, review, and resolution of patient or resident complaints.
- To receive information concerning an experimental procedure proposed as a part of his or her care and to refuse to participate in the experimental procedure without jeopardizing his or her continuing care.

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Patient Rights & Responsibilities - Michigan

- To receive and examine an explanation of his or her bill regardless of the source of payment and to receive, upon request, information relating to financial assistance available through the health facility or agency.
- To know who is responsible for and who is providing his or her direct care, to receive information concerning his or her continuing health needs and alternatives for meeting those needs, and to be involved in his or her discharge planning, if appropriate.
- To associate and have private communications and consultations with his or her physician, attorney, or any other person of his or her choice.
- To send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented by the attending physician in the medical record.
- To exercise fully his or her civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices. The health facility or agency shall encourage and assist in the fullest possible exercise of these rights.
- To meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contradicted as documented by the attending physician in the medical record.
- To be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
- To be free from performing services for the health facility or agency that are not included for therapeutic purposes in the plan of care.
- To receive the health facility or agency rules and regulations affecting patient or resident care and conduct.
- To receive adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.

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Medication Sheet

Patient Name: _____ Date _____

Allergies:_____

Pharmacy Number: _____

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

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30 Day Blood Glucose Log

Patient Name:_______________________________________ **DOB:**____________

Start Date:_______________________ **End Date:** _________________________

Date	Before Breakfast	After Breakfast	Before Lunch	After Lunch	Before Dinner	After Dinner	Night/ Bedtime	Other

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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: _____

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Laboratory Information & Policies

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions, limitations and authorization requirements.
- A patient has the right to have their labs drawn at any other lab draw site & may simply request that their lab orders be printed and/or sent to their laboratory of choice.
- Many insurance companies will not pay for tests that they feel are "not medically necessary "even if your provider feels they are; each insurance company has its own definition of "medically necessary".
- Likewise, some insurance companies will not pay for "routine" lab tests and will require a medical diagnosis for each and every test that is done.
- Occasionally adding additional appropriate diagnostic codes can be resubmitted by our office to have your labs covered; in such cases please speak to one of our office nurses to see if any coding can be re-submitted for processing on your behalf.
- In general, questions regarding bills you receive from Laboratory facilities should be directed towards the Lab and/or your insurance carrier.
- If you have a secondary insurance, please be certain to communicate this to your primary insurance & the Laboratory so that they can forward the claim to the secondary carrier when indicated.
- If you receive a request for information from your insurance company, please complete and return the request immediately. Delay in payment from the insurance company may result in a transfer of responsibility from the insurance company to the patient

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

Patients Signature: _____ Date: _____

Name of Patient: _____ Patient DOB: _____

Name of Patient Representative: _____ (if signed for Patient above)

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Prescription Refill agreement

- The Providers at Grace Endocrine Services can focus their time and attention to patient care; I will make every effort to have medications filled at the time of my office visit.
- I will bring all my prescription bottles or a detailed list of medications to each appointment.
- (For female patients) I will notify the provider or nurse if there is any chance I may be pregnant.
- I agree to allow 48 hours or two business days for prescription refill requests to be processed.
- I understand that refills should be requested Mon-Thurs, and that refills requested after 4:00 pm on Thursday or anytime on Friday may not be processed until Monday.
- I understand that a follow-up visit may be required in order to refill my medication.
- I understand that for safety reasons the office does **NOT** accept auto-generated refill requests from pharmacies, as the doses/medications are often incorrect or discontinued.
- I agree to take all medications as instructed, and will not alter or change the dosage without consulting a medical provider.
- I will keep all follow-up appointments as recommended so that my medications and any relevant lab work can be monitored.
- I will not alter or forge a prescription; this is a felony and will be reported.
- I understand that any and all controlled substances require an office visit with the provider, and only a 30 day supply will be dispensed at any time.
- I will not trade, sell, or give away my medication.
- I will not drive while taking any narcotic or controlled substance.
- I will not combine alcohol with any narcotic or controlled substance.
- I understand only emergency medications will be called in after-hours and will incur a fee.
- I understand controlled substances will **never** be called in or refilled after hours or without an office visit.

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

Patients Signature: _____ Date: _____

Name of Patient: _____ Patient DOB: _____

Name of Patient Representative: _____ (if signed for Patient above)