Internal Medicine and Pediatrics of Bloomfield, PC
Steve Kallabat, MD
Azrael Paredes, MD

Registration Information

Last Name____ First Name___________________________________ MI_____

Date of Birth______/_____/_____ Age______ Social Security Number _____-_____-_____

Address____City_________________ State_____ Zip_____________

Cell Phone (______)___________________ Home Phone (_______)__________________________

Work Phone (______)______________________ext._____ Email ____
Please circle which number is best for us to reach you: **Cell** **Home** **Work**

Emergency Contact:________________________________ Relationship_________________ Phone ____________________
Can we discuss your medical/financial information with anyone? **Yes** or **NO**
If so, who?_______________________________________ Relationship__________________ Phone ___________________

Local Pharmacy Name______________________________ Address ______________________Phone___________________

Mail Order Pharmacy_______________________________Address________________________Phone___________________

Please circle which race best represents you: **White /African-American/Asian/Other:_______________________________**
Please circle which ethnicity best represents you: **Hispanic/Latino Other:____**
What Language is spoken in home: ____
Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated**

Insurance Information

Primary Insurance:____

Subscriber Name:____SSN____________________DOB_____________

Patient relationship to subscriber: **Self** **Spouse** **Parent** **Child** **Other**____

Secondary Insurance:____

Primary Insurance:____

Subscriber Name:____SSN____________________DOB_____________
Patient relationship to subscriber: **Self** **Spouse** **Parent** **Child** **Other**_____________

Referral Source – How did you learn about our practice?
Newspaper **Phonebook** **Brochure** **Radio** **Other**_______

Physician Referral____
Name
Friend or Family Member____
Name

Authorization for release of medical records and assignment of benefits

I hereby authorize the release of medical 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 Internal Medicine and Pediatrics of Bloomfield, PC. 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____ Date________________________________

Internal Medicine and Pediatrics of Bloomfield, PC

This is an agreement between Internal Medicine and Pediatrics of Bloomfield, PC, located at 1109 W. Long Lake Road, Bloomfield Hills, MI 48302 and ____located at____.

Name Address

In this agreement the words “you”, “your”, and “yours” means the patient. The word “account” means the account that has been established in your name to which charges are made and payments are credited. The words “we”, “us”, and “our” refers to Internal Medicine and Pediatrics of Bloomfield, PC.

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 charges, if any, and any payments or credits applied to your account during the month.

Payment Options: You may choose pt pay by cash or credit card on the day that treatment is rendered.

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 at the time service is rendered. It is the insurance company that makes the final determinations 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 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.

Statement Fee: A billing fee of $5 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.

Address:
1109 W. Long Lake Rd.
Bloomfield Hills, MI 48302

Contact:
Phone: 248-723-2400
Fax: 248-723-5785

Internal Medicine and Pediatrics of Bloomfield, PC

Co-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 waive these fees.

Deductibles: Patients who have a high deductible insurance policy will be required to pay a portion of the office visit at the time of service. You will be responsible for the difference of the fee collected on the day of service and the amount billed to your insurance company.

Payment: I assign and authorize payment from my insurance company directly to Internal Medicine and Pediatrics of Bloomfield, for any and all services rendered. I agree to pay, at the time of service or on an interim basis (agreed upon by Internal Medicine and Pediatrics), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay Internal Medicine and Pediatrics of Bloomfield, PC all charges for services rendered irrespective of any disputes or disagreements between me and my insurance company.

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

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

No Shows: Patients who do not keep their appointment will be charged a fee of $25. If this fee is not paid before the next visit, patient will not be seen until this is taken care of.

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. There will also be a 30% additional cost added to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all actual attorney 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 have 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 the 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 make a written request and pay a $25 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.

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 be BCBS as a courtesy in order for you to be reimbursed by the carrier.

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 herein and the agreement will be in full force and effect.

Patient Name: ___________________________________ Responsible Party: _____________________
(if not the patient)

Patient Signature:_________________________________ Date: _________________________________

Internal Medicine and Pediatrics of Bloomfield, PC

GENERAL CONSENT TO TREATMENT

Patient's Name: ___________________________________ Date of Birth_________________

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 as a patient of Internal Medicine and Pediatrics of Bloomfield am aware and clearly understand that in the course of providing care, providers will share patient information with other providers who are involved in the patient's care, as appropriate. I authorize Internal Medicine and Pediatrics of Bloomfield to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information may 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. See Notice of Privacy Practices for further information.
3. **Human Immunodeficiency Virus (HIV) and Hepatitis B (HBV) Testing**: I understand and agree that, in accordance with State Law, and HIV or HPV test may be performed upon me in the event a healthcare worker sustains a significant exposure to my blood or body fluids. The results of my test will be treated confidentially.
4. **Testing and Disposal of Specimens and Tissues**: I authorize William Beaumont Hospital 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. **No Guarantees**: I am aware that the practice of medicine and surgery are 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.

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/patient advocate/closest relative (if patient is unable to consent)*

-- ---------------------------------------

Signature of Witness *Please indicate relationship*