SPARROW MEDICAL GROUP GENERAL SURGERY

PATIENT LEGAL NAME: ____

ADDRESS: ____

Street City State Zip Code

TELEPHONE—Home:________________________ Work:________________________ Cell:________________________

As a service to our clients we provide a courtesy appointment reminder call and possibly other important calls. By providing your cell phone number, you consent to receiving such calls at this number.

E-MAIL ADDRESS: ____

BIRTHDATE: __________________ AGE: ________ SS#: ____

PRIMARY LANGUAGE: ________________________ GENDER: Female Male MARITAL STATUS: Single Married Divorced Widowed

RACE: African American American Indian Asian White Hispanic Other __________________

EMPLOYER: ____ PHONE NUMBER: ____________________________

PRIMARY CARE PHYSICIAN: ________________________________ (Must not be left blank)

PHARMACY NAME: ____________________________________ PHONE NUMBER: ____________________________

IS THIS A WORK-RELATED INJURY: No Yes IF WORKER'S COMP, DATE OF INJURY: ___________________

CLAIM NUMBER: ____

PRIMARY INSURANCE: INSURANCE COMPANY: ____

CONTRACT NUMBER: ____ GROUP NUMBER: __________________

SUBSCRIBERS' NAME: ____ DATE OF BIRTH: __________________

SECONDARY INSURANCE: INSURANCE COMPANY: ____

CONTRACT NUMBER: ____ GROUP NUMBER: __________________

SUBSCRIBERS' NAME: ____ DATE OF BIRTH: __________________

EMERGENCY CONTACT PERSON: ____ PHONE: ________________________

NAME OF NEAREST LIVING RELATIVE/FRIEND: __________________________ PHONE ________________________

IF PATIENT IS A MINOR:

MOTHER'S NAME: ____ PHONE: __________________________

FATHER'S NAME: ____ PHONE: __________________________

WE DO BILL AND ACCEPT MOST INSURANCE COMPANIES' USUAL AND CUSTOMARY FEES. YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLES, COPAYS OR SERVICES NOT PAID BY YOUR INSURANCE COMPANY. IF YOU ARE NOT INSURED, YOU ARE RESPONSIBLE FOR ALL SERVICES RENDERED. PLEASE CONTACT OUR BILLING DEPARTMENT IF YOU HAVE ANY QUESTIONS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO SPARROW MEDICAL GROUP. A COPY OF THIS SIGNATURE AND STATEMENT SHALL BE AS VALID AS THE ORIGINAL.

____ ____________________________

Patient's Signature or Parent if Minor Date

In order to comply with government reporting system and to provide you with appropriate advance planning for your healthcare, please respond to the following questions.

Name___________________________________ **Date of Birth**__________ **Date**_______

1. Do you have a living will?

   ______Yes No

   If yes, provide the name of your Healthcare or Durable Power of Attorney

2. In the event of a life threatening event please check all that apply:

   ______Decline to answer at this time

   ______Full Resuscitation (All life saving measures)

   ______Limited life saving measures (Please provide a copy of your complete Living Will)

   ______No life saving measures (Please provide a copy of your complete Living Will)

Please give this complete form to the medical assistant when you are called to the exam room.

Thank you

SMG General Surgery

"Medicare One Time Authorization Agreement"

Statement to Permit Payment of Medicare Benefits to Providers, Physicians, and Patients

Name of Beneficiary:______________________________

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Sparrow's Physician/Provider. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

_________________________________ _________________

Signature of patient Date

For services furnished by a provider, or on an outpatient basis, this request is effective until revoked by the beneficiary. If a patient objects to part of the request for payment, the provider should annotate accordingly.

Commercial Insurance Release

I hereby authorize the release to my insurance company(s), or their designee, any medical information necessary to properly process by bill (including any information that may be contained in the records pertaining to AIDS, or HIV antibody). I authorize payment of medical benefits to be made to the providers for services rendered.

_________________________________ _________________

Signature of patient, parent, or guardian Date

I authorize SMG General Surgery Lansing, or designees to perform routine diagnostic procedures and medical treatment.

____

Print name of patient

_________________________________ _________________

Signature of patient, parent, or guardian Date

SMG General Surgery Lansing

Release of Medical Information Consent Form

SMG General Surgeons may release information over the telephone to the following persons. If there are no names written in this section, we WILL NOT be able to release any information to anyone other than YOU.

Name: ____ Relationship__________

Name: ____ Relationship__________

Name: ____ Relationship__________

Name: ____ Relationship__________

It is my responsibility to notify SMG General Surgery Lansing of any changes to the above instructions.

Patient Name: ____

Patient Signature:____

DOB_____________ Date_____________

Notice of Privacy Practices Acknowledgement

I acknowledge that:

A copy of the Sparrow Health System's Notice of Privacy Practices was made available to me at the location where I received health care services.

The *Notice of Privacy Practices* was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. I know that I can ask for a copy of the *Notice of Privacy Practices* to take with me.

If I came in for health care services in an emergency treatment situation, I was able to view the *Notice of Privacy Practices* as soon as reasonably practicable after the emergency treatment situation.

______________________________ ______________________
Printed name of patient or patient's representative Date of Birth

______________________________ ______________________
Signature of patient or patient's representative Date

____
Relationship to patient (if other than patient)

Complete only if patient or representative signs by use of a mark:

____
Printed name of witness

______________________________ ______________________
Signature of witness Date

____
Printed name of witness

____
Signature of witness Date

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow has verified the identification of ______________________(patient's representative name) by. (type of verification, e.g., driver's license) and that in his/her capacity of______________________(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

______________________________ ______________________
Associate name and signature Date

TO BE COMPLETED BY SPARROW HEALTH SYSTEM

If an acknowledgment is not obtained, describe Sparrow Health System's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained.

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