

*Internal Medicine and Pediatrics of Bloomfield, PC*

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**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 Signature/Guardian Signature** \_\_\_\_\_ **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 you 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 for office visit and \$100.00 for physicals. 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 health care 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*

**Internal Medicine & Pediatrics of Bloomfield, PC  
Pediatric History Form**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Have any members of your family (parents, brothers, sisters, grandparents, aunts, uncles) ever had:

	YES	NO
High Blood Pressure		
Heart Trouble		
Diabetes		
Arthritis		
Tuberculosis		

	YES	NO
Cancer		
Asthma		
Mental Disorders		
Other	_____	
	_____	

**Birth and Development:**

Term (# of weeks): \_\_\_\_\_ Delivery (Vaginal or C-section): \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Condition at Birth \_\_\_\_\_

Condition 1st week: \_\_\_\_\_

Feeding: \_\_\_\_\_

Convulsions: \_\_\_\_\_

Sat Up: \_\_\_\_\_ Stood: \_\_\_\_\_

Short Sentences: \_\_\_\_\_ First Teeth: \_\_\_\_\_

Potty Training: \_\_\_\_\_ Bladder: \_\_\_\_\_

Cyanosis: \_\_\_\_\_

Jaundice: \_\_\_\_\_

Walked: \_\_\_\_\_

Bowels: \_\_\_\_\_

**Has your child ever had:**

	YES	NO
Acid Reflux		
Anemia		
Asthma		
Behavior Problem		
Bleeding Disorder		
Chicken Pox		
Concussion		
Diabetes		
Ear Infections		
Headaches		
Heart Disease		
Heart Murmur		
Hepatitis		
Kidney Disease		
Pneumonia		
Rheumatic Fever		
Scarlet Fever		
Seasonal Allergies		
Seizure Disorder		
Sickle Cell		
Skin Irritation		
Thyroid Disease		
Urinary Tract Infection		

**Past Surgeries:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_

**Social History**

**Household Members:** \_\_\_\_\_

(including pets) \_\_\_\_\_

Cigarette Use YES NO Years Smoked \_\_\_\_\_

Packs Per Day \_\_\_\_\_

Alcohol Use YES NO Drinks Per Day \_\_\_\_\_

Drug Use YES NO Date Last Used \_\_\_\_\_

Type of Drug \_\_\_\_\_

# How To Get Lab and Imaging Test Results

## **1. Signing for the patient portal is easy.**

**An email will be sent to your email address with a link.**

(If you deleted/lost the email, please ask the front desk to resend it.)

Sign up for patient portal **ONLY** through the email we send you titled “**Follow My Health.**” You must sign up by **clicking on this email from a computer (not a tablet or smartphone.)** Do not register from our website.

Follow the steps to register from the patient portal. You can create an account with the FMH secure log in, or login through an existing account like Google or Yahoo. With an existing account it may be easier to remember your password.

Signing up with FMH secure login: Password should be at least 8 characters in length, and include at least one numeric and one special character, such as !@#\$%^&\*-(

**Write down your password** in a secure spot.

**The first time you log into the app, you will be prompted to enter your 4 digit password to verify that it is you. It will be 1234.**

## **2. Download app for your phone for easy access to the patient portal.**

In your app store search: “**Follow My Health**” and download and open and login.

The app name appears exactly as FollowMyHealth® Mobile

## **3. Once registered, check your labs online:** <https://www.followmyhealth.com/>

Or access from our website: [www.medpedsdoc.com](http://www.medpedsdoc.com) – click the patient portal tab on the left.

## **4. Lab results protocol:**

All lab results will be released to the Patient Portal once reviewed by the physician, typically within 1-3 business days. If not on the patient portal, labs are released via mail 7 days after the blood draw. Only urgent abnormal labs are resulted by telephone.

*We strongly encourage all patients to register for the patient portal.*

**5. The patient portal is not monitored as an inbox.** Do not reply to messages or send questions through this way. The patient portal is used for outgoing messages only, although it does allow them to go through. For medical questions please call our office (248) 723-2400, or for medical emergencies call 911 or go to the ER.

Thank you for taking responsibility for your health.

The healthiest people are active and knowledgeable about their medical care!

I understand and agree to the above policies: \_\_\_\_\_ Date: \_\_\_\_\_