Flat Rock Physicians

New Patient Registration

Last Name:	Registration Date:
First Name:	How did you hear about us?
Preferred Name:	**Do we have permission to call you?**
Middle Name, Suffix:	Yes___ No___
Former Last Name:	Guardian Last Name:
Sex:	First Name:
Date of Birth:	Middle Name:
SSN:	**Emergency Contact**
Address:	Name:
Address:	**Relationship**
City:	Home Phone:
Zip Code:	Cell Phone:
State:	**Employment**
Home Phone:	Employer Name:
Work Phone:	Employer Phone:
Cell Phone:	Usual Occupation:
Patient Email:	Usual Industry:
Contact Preference:	**Mailing Address**
Language Spoken:	Address:
Race:	Address:
Ethnicity:	Zip:
Marital Status:	City:
	State:
Guarantor Information Patient Relationship to guarantor:	Address:
Last Name:	Address:
First Name:	Zip:
Middle Name:	City:
	State:

There is a $100.00 No Show Fee/less than 24 hour cancellation for New Patients and a $100.00 No show/Fee/ less than 24 hour cancellation fee for established patients.

Flat Rock Physicians, P.L.C. *Family Medicine*

25620 Gibraltar Rd. Telephone (734)789-9355

Flat Rock, MI 48134 Fax (734)789-1520

WELCOME TO OUR OFFICE

We are extremely pleased that you have chosen our office to serve your health needs. Our staff is looking forward to helping you with any concerns that you have and help you in maintaining excellent health.

Besides staying in touch with the latest technology to bring our patients the best health care possible, we strive to keep our costs at a reasonable level. In an effort to keep fees reasonable and to continue to provide quality care, we maintain the following payment policy:

1. **Payment for all treatment is expected at the time the treatment is rendered.**
2. **Cash, Checks, MasterCard and Visa are accepted.**
3. **For any return checks unpaid, there will be a minimum of a $30.00 fee.**
4. **Treatment requiring insurance co-pays must be paid at the time of service.**
5. **Missed appointments without at least a 24-hour prior notice may be subject to a $50.00 cancelation fee.**
6. **Any account requiring a statement may be charged a 15% late fee on the balance not paid by the due date.**

For all patients with Health Insurance:

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Please remember your policy is between you and your insurance company not with the insurance company and Flat Rock Physicians, P.L.C. We are happy to bill your insurance carrier; however, we do require payment for all uncovered services, deductibles, co-payments or out of network liabilities to be paid at each appointment. While filing of insurance claims is a courtesy we extend to our patients, ultimately all charges are your responsibility for the date services are rendered in the event your insurance company does not pay what was originally expected. If your insurance company declines payment after the initial submission, it is your responsibility to contact your insurance company for payment. Therefore, you are responsible for payment in full on your account.

Signature **Date**

Flat Rock Physicians

Office Policy and Fee Disclosure

Insurance

All co-pays and deductibles must be paid at the time of service. This arrangement is part of **your** contractual agreement with **your** insurance company. **You** are required to inform us of **your** insurance prior to receiving services. Please also keep in mind that it is **your** responsibility to know **your** insurance and benefits. As well as which Lab your insurance will cover. (We have a Qu draw station located in our office but not all insurances cover this particular lab.) Additionally, it is the patient's responsibility to know if a referral is required by **your** insurance company and obtain it prior to the examination.

Assignment and Release

I request that payment of authorized Medical or Medicare benefits be made to me on my behalf of David G. Patterson, D.O., P.C. or Colleen Browne, D.O., P.C. for services furnished me by the physician. I authorize any holder of medical information about me to my insurance company and its agents get any information necessary to pay the claim. If "other insurance" is indicated in item 9 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, business associate or agency shown. In Medical or/ Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medical and/or Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance, non-covered services, and non assigned claims. Coinsurance and the deductible are based upon the charge of the assigned Medical and /or Medicare carrier. **I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING REFERRALS FROM MY PRIMARY CARE PHYSICIAN IF PRIOR AUTHORIZITION IS REQUIRED BY MY INSURANCE. ALL PROFESSIONAL FEES ARE NON-REFUNDABLE.** Additionally, in the event that a personal check is returned from the bank for insufficient funds. I agree to pay a returned check fee of $45.00 added to my balance as well as any bank charges. I also understand and agree to pay a $4.00 monthly fee on all statements past due by 60 days. I understand that in the event of my account is turned over to an outside collection agency, I agree to reimburse Flat Rock Physicians the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses including reasonable attorney fees incurred in such collection efforts.

Patients are also responsible to ensure that they are signed up for either David G. Patterson D.O. , or Colleen Browne D.O. as their PCP (Primary Care Physician). If any other physician is assigned as the PCP, the patient will be billed for the entire visit.

No Show Fee

Advanced notification is required if you are unable to keep your appointment. A $50.00 fee will be charged for failure to give 24 hours notice for cancelling for the first missed appointment and a $100.00 dollar fee for every missed appointment after that.

Print Name_____

Signature_____Date:_____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorized my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted on myself, and/or my dependent, and that I will be bound by my signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company(s) to pay and hereby assign directly

David G. Patterson, D.O., P.C. or Colleen D. Browne D.O., P.L.C., benefits, if any, otherwise payable to me for his/her services. **I understand that I am financially responsible for all charges incurred. This contract supersedes any and all contracts between your physician and your health insurance company.**

Signature: _____ Date: _____

Privacy Acknowledgement

I have received the notice of privacy and I have been provided with the opportunity to review it.

Signature: _____ Date: _____

Personal Representative's Name: _____ Date: _____