

Appt. \_\_\_\_\_  
Date: \_\_\_\_\_

**NOVI INTERNAL MEDICINE AND PEDIATRICS, PLLC**  
**PATIENT REGISTRATION**



(Please *print* information and give your insurance card and driver's license to the receptionist so a copy can be made. Thank you.)

**Print Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

Employment Status:  Full-Time  Part-Time  Retired  Self-Employed  Unemployed  Student

Marital Status:  Single  Married  Divorced  Separated  Widowed

Do you have any Medication Allergies? Please list \_\_\_\_\_

Emergency Contact: (other than parent/spouse) \_\_\_\_\_ Relationship To You: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Pager/Cell Phone: \_\_\_\_\_

How did you hear about our practice?

Beaumont  Advertising  Insurance  www.novidocs.com  Welcome Wagon  Other: \_\_\_\_\_

Heard about us through a Family Member, Friend or other Physician?

We would like to thank them. Please print their name: \_\_\_\_\_

**Person who should receive bill (guarantor or responsible party)**

Name: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employment Status of guarantor or responsible party:  Full-Time  Part-Time  Retired  Self-Employed  Unemployed

**PRIMARY INSURANCE**

Social Security #: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Ins. Name: \_\_\_\_\_ Policy: \_\_\_\_\_

Ins. Address: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Subscriber Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE**

Social Security #: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Ins. Name: \_\_\_\_\_ Policy: \_\_\_\_\_

Ins. Address: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Subscriber Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**TERTIARY INSURANCE**

Social Security #: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Ins. Name: \_\_\_\_\_ Policy: \_\_\_\_\_

Ins. Address: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Subscriber Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Print Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Consent for Clinic Services:** I request and authorize health care services that my physician(s) or designee advise. These may include diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical care. To that end, Instructors working at the Facility oversee students and trainee students and trainees may visit or care for me and may review my health care information as part of their education. I will tell my nurse or doctor if I do not want students or trainees involved in my care. I understand the Facility may withdraw from me specimens of blood, urine and other bodily fluids/tissues for diagnostic purposes, and may perform other tests not related to my diagnosis with these specimens, and the Facility may dispose of these specimens as it chooses, by law.

**Payment:** We accept cash, debit cards, Visa, MasterCard, and personal checks, with photo ID. After services have been rendered will bill your insurance company, and any outstanding balances are due within 30 days.

**Insurance:** Remember, your insurance is a contract between you and your insurance company. Novi Internal Medicine and Pediatrics is not responsible for your deductibles, co-payments, co-insurance payments, percentages, deductibles, non-covered services, or services rendered without proper referral authorization, or denied services. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility.

**Insurance Deadlines:** Many insurance companies have "timely filling deadlines". It is your responsibility to inform us of any insurance changes. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. Please contact your insurance company to determine if our practice has a contract with your insurance company.

**Immunizations:** Please inform us if you do not have any immunization coverage, partial, or limited coverage. You may be eligible for Vaccine for Children (VFC) program.

**Referrals:** I understand it is my responsibility to notify us if you may need an authorization and/or a referral within 10 days of your appointment date. You could incur a fee for failure to notify us for a referral or a pre-certification for services. Some insurance companies need pre-certification/authorization prior to services rendered. Your primary care physician has the right to refuse to give you a referral, if they deem it is not medically necessary, per your insurance contract.

**Co-Payments:** All co-payments are expected at time of service and may be asked for prior to seeing your physician. When you signed up with your insurance company, you signed an agreement between you and your insurance company stating co-payment is due at time of service.

**Returned Checks:** All returned checks will be assessed a \$25 returned check fee, in addition to the amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check, plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

**Missed Appointments:** We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel within a minimum of two hours notice in order for another patient to be scheduled. If you do not cancel by the deadline, a \$25 missed appointment fee will be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment time.

**Collection Agency:** Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement may be assessed \$5 rebilling fee. All balances reaching 90 days past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

**Personal Valuables:** I understand that the Facility has a safe where patients may store their money and small valuables. I understand that the Facility is not responsible for loss or damage to any property.

**No Guarantees or Assurances:** The Facility has made no guarantees or assurances about the results of my office care or health care. I understand that a patient will receive the usual and ordinary care rendered in this community, and that no other contract, written or implied, is made.

**Responsibility & Release of Information:** I understand that I am responsible for my bill, and that I assign and transfer to the Facility all health care benefits applicable to my care, and request payments on my behalf for all services provided by the facility. I agree to personally pay for any charges not covered by or collected from any applicable health care benefit charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurances. I authorize Novi Internal Medicine and Pediatrics, and Dr. Louis W. Schwartz, to act as my agent in helping me obtain payment from my insurance company or third party payors for review of quality, utilization, charges or workplace injuries, or employment physicals. Including information as defined by statute and Michigan Department of Public Health Rules and Federal Regulations. This authorization for release of information is effective so long as necessary. This authorization may be revoked at any earlier time unless the facility has already asked or released information in reliance to it.

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witnessed by Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_