CLEARWATER FAMILY MEDICINE

A division of Arcturus Healthcare PLC

64321 Van Dyke | Washington Twp., Michigan 48095

REGISTRATION DATA & INSURANCE INFORMATION

Please Print

Welcome and thank you for choosing our office as your Primary Care Physician Office. Your medical care is very important to us. Ask us how we can improve your healthcare through our Patient Centered Medical Home. Visit our website at www.clearwatermedicine.com

Date: _____

Last 4 of your Social Security

(Required for Medicare patients) _____

PATIENT INFORMATION Do you have an Advance Directive? YES / NO

_____ Last Name | _____ First Name | _____ MI | _____/_____/_____ Birthdate | _____ Sex

_____ Address | _____ City | _____ State | _____ Zip

Please indicate your Primary phone: Home / Work / Cell

(_____) _____ Home Phone | (_____) _____ Work Phone | (_____) _____ Cell Phone

_____ Pharmacy Name | (_____) _____ Pharmacy Phone

Race: ○ Caucasian ○ African American ○ Native Indian ○ Asian ○ Other _____

Ethnicity: ○ Hispanic ○ Other _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated **MAIDEN NAME**_____

EMERGENCY CONTACT:

_____ Name | _____ Relationship | (_____)_____ Phone Number

EMPLOYER INFORMATION:

_____ Employer | _____ Occupation

Circle one: Full Time/ Part Time/ Not Employed
Self Employed/ Retired/ Military

INSURANCE SUBSCRIBER: (person who provides the insurance)

_____ Name | _____ Relationship | _____/_____/_____ Subscriber Date of Birth

PERSON RESPONSIBLE FOR PAYMENTS:

_____ Name | _____ Relationship | _____ Address

I request the following person(s) to receive information regarding my protected health information.

Name_____Relation_____Birth Date _____

Name_____Relation_____Birth Date _____

For all results, and other issues, I wish to be contacted in the following manner (check all that apply):

Preferred Daytime Phone Number:_____

○ OK to leave a message with call-back number only

○ OK to leave message with detailed information

○ OK to leave detailed message with the following person(s):

_____

Web Portal: Secured Information via Email
Email Address: _____

With my consent Clearwater Family Medicine, a division of Arcturus Healthcare PLC, may mail to my home or other designated location, or contact via electronic exchange, any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards or test results. I have a right to request Clearwater Family Medicine, a division of Arcturus Healthcare PLC, restrict how it uses or discloses my personal healthcare information to carry out treatment, payment, and healthcare operations. The practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

I authorize payment of insurance benefits directly to Clearwater Family Medicine, a division of Arcturus Healthcare PLC. I agree that I shall be legally responsible for any medical or surgical charge incurred in the course of my treatment, including those that are rejected as co-pay, deductible, or unpaid service, in excess of any hospitalization or health insurance that might be applicable.

I assign payment of authorized benefits to Clearwater Family Medicine, a division of Arcturus Healthcare PLC, on my behalf for services rendered. I understand I am responsible for the charges not covered by my health insurance policy. I am also required to pay my co-pay at time of service. If not I will be billed $25.00.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Clearwater Family Medicine, a division of Arcturus Healthcare PLC, may decline to provide treatment to me.

By signing this form, I am consenting Clearwater Family Medicine, a division of Arcturus Healthcare PLC, the use and disclosure of my personal health information to carry out treatment, payment, and healthcare operations. I request and authorize medical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care.

CONSENT TO TESTING

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues, or products may be obtained and that tests will be performed upon such fluids, and products, and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS), I will be counseled by my physician and I will be given a choice of consenting in writing to such testing. I have been informed that my written consent to testing HIV antibody or other communicable diseases is not required by law in situations where a health care provider sustains an exposure to my blood or body fluids.

_____ _____

Date Patient Name

_____ _____

Witness Signature of Patient or Authorized Guardian

PATIENT CONSENT FOR USE, TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Clearwater Family Medicine, a division of Arcturus Healthcare PLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Clearwater Family Medicine, a division of Arcturus Healthcare PLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent. Clearwater Family Medicine, a division of Arcturus Healthcare PLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have access to this office's Notice of Privacy Practices Form.

WITNESSES:

_____

Patient Name (please print)

_____ _____

Patient Signature or Authorized Guardian Witness

_____ _____

Date Date

Documentation of Failure to Obtain Signed Acknowledgement

On_____,_____presented this Acknowledgement of Receipt of Notice of Privacy Practices Form to_____(the "patient"). The patient refused to provide a signature when requested.