NORTHLAND FAMILY CARE, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Social Security Number
Address	Sex	Marital Status
City, State, Zip	Home Phone	Cell Phone
Primary Employer	Work Phone	Email
Employer's Address	City, State, Zip	
Primary Physician / Referred By	Communication Preference: Please check at least one and provide information ❑ Home Phone _____ ❑ Cell Phone _____ ❑ Email _____	
Medical Information may be given to those checked: ❑ Mother ❑ Father ❑ Other/Relationship_____		
Emergency Contact: Name, Relationship	Emergency Contact Phone Number	
Primary Caregiver (for Child or Elderly) - (Last, First, MI)	Primary Caregiver Contact Number (home, cell)	

PATIENT DEMOGRAPHICS - Please Check Where Applicable

Student ❑ YES ❑ NO ❑ Full-time Status ❑ Part-time Status

Retired ❑ YES ❑ NO

Veteran or Current Military Status: ❑ YES ❑ NO

Race:

❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Asian
❑ Native Hawaiian or Other Pacific Islander ❑ Unknown ❑ Decline

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown ❑ Decline

Preferred Language Spoken

Do you smoke or use Tobacco Products _____Yes _____No

Revised April 2019 - Thank you for your assistance with government regulations

PATIENT REGISTRATION FORM

****PLEASE NOTE THAT ALL CO-PAYS ARE DUE AT TIME OF SERVICE, THANK YOU****

PRIMARY INSURANCE INFORMATION

Name of PRIMARY Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group#	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

SECONDARY INSURANCE INFORMATION

Name of SECONDARY Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group#	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

PLEASE ATTACH A COPY OF INSURANCE CARD- IF NO COPY IS AVAILABLE, THE ACCOUNT WILL BE CONSIDERED "SELF-PAY"

Medical Authorization: The undersigned permits the physicians and all other personnel caring for the patient to examine, recommend treatment, and explain any associated risk involved. The undersigned also understands that this care may include diagnostic testing, examinations, or surgical treatment and no guarantees have been made regarding the outcome of this care.

Financial Agreement: I, the undersigned agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by Northland Family Care on my behalf, negotiating payments through my insurance company is ultimately my obligation. I understand that payment will be made at the time of services rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me showing the balance due from me and will be considered past due after 30 days. If I am unable to make payment in full, I understand that I should contact the business office immediately to set up a payment arrangement. I understand that if no payment has been received or financial arrangements made on my balance, my account may be sent to collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as any fees associated with the collection process.

SIGNATURE DATE

NORTHLAND FAMILY CARE, P.C.

Welcome to Your Patient-Centered Medical Home

Northland Family Care's PCMH Philosophy: *Providing care that is respectful of and responsive to the individual patient preferences, needs and values ensuring that patient values guide our clinical decisions.*

Patient-Centered is a way of saying that you, the patient, are the most important person in the health care system. You are the center of your healthcare.

A Medical Home is an approach that yields both better healthcare care and lower costs. With your Medical Home, you are joining a team that provides centralized, comprehensive, coordinated primary evidence-based care and cultivates partnerships between patients, their personal physicians, the care-giving team, and the patient's family.

A Patient-Centered Medical Home is a Partnership between the patient and their physician.

Being a part of a PCMH, your doctor will:

- Work with you to improve your health
- Review your medications at every visit and discuss with you any interactions or contraindications
- Develop a personal action plan with you to address your chronic conditions
- Set goals with you and monitor your progress
- Use computer technology to monitor your progress and determine if your health is Improving
- Inform you of all test results
- Help you take control of your health by providing you educational material, hosting group visits and linking you to other community programs and resources
- Provide you 24-hour access to a clinical decision-maker by phone
- Have arrangements with after-hours care to be informed of your visit or emergent treatment within 24 hours or the next business day
- Reserve space in our schedule for you to accommodate a same-day appointment
- Refer you to available community resources when the need arises
- Update your medical, family, social and medication history during office visits
- Offer self-management and behavioral health support

By choosing to participate in a PCMH, YOU (the patient) agrees to:

- Provide my doctor with my entire medical history
- Tell my doctor all of the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Adhere to the action plan designed by my doctors
- Consult my doctor before making my own appointment with a specialist
- Request that any other doctor I see sends my doctor a report including copies of lab work, test results and any x-rays
- Know my insurance and what it covers
- Provide the office feedback on how they can improve

NORTHLAND FAMILY CARE, P.C.

Patient-Centered Medical Home Patient Compact

A Patient Centered Medical Home is a trusting partnership between a doctor-led healthcare team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the roll of each in the total healthcare program.

We trust you, our patient to:

- Tell us what you know about your health and illnesses
- Tell us about your needs and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon, or let us know why you cannot so we can try to help and change the plan
- Tell us what medications you are taking and ask for refills at your office visit when you need one
- Let us know when you see other doctors and what medications they put you on or change
- Ask others to send us a report about your care when you see them
- Learn about your insurance so you know what it covers
- Keep your appointment as scheduled, or call and let us know you cannot at least 24 hours in advance
- Pay your share of the visit fee when you are seen in the office
- Give us feedback so we can improve our service

As we build your Medical Home you will notice some changes in the way we provide care, but many things will stay the same. We will continue to:

- Provide you with your own doctor who knows you and your family whenever he/she is available
- Respect you as an individual – we will not make judgments based on race, religion, sex or disability
- Respect your privacy – your medical information will not be shared with anyone unless you give us written permission or it is required by law
- Provide care given by a team of people led by your doctor
- Give the care you need when you need it
- Give the care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours a day, 7 days a week
- Take care of short illness, long-term disease and give advice to help you stay healthy
- Tell you about your health and illness in a way you can understand

Over the next several months, you may notice that:

- We ask what your health care goal is, or what you want to do to improve your health
- We use current best evidence in decision making about your care and offer support for self-management of your health and healthcare
- We ask you to help us plan your care, and let us know if you think you can follow the plan
- We will give you a written copy of the care plan
- The care team members are doing more and/or different parts of the care
- We remind you when tests are due so you can receive the best quality care
- We may ask you to have blood tests done before your visits so the doctor has the results at your visit
- We may offer you a chance to join in a special type of doctor's visit called a "group visit"
- We continue to increase the use of technology in the way we manager your healthcare in ways such as ePrescriptions, eVisits, and online bill pay

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above, and we will acknowledge our agreement to you.

Either you or your doctor may end this partnership at any time. If you choose to end the partnership, please notify us and tell us why. If your doctor decides to stop seeing you, we will notify you with an explanation as to why. With your written permission, we will forward a copy of your information to your next doctor.

_____	_____	_____	_____
Patient Signature	Date of Birth	Date	Physician Signature

NORTHLAND FAMILY CARE, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health Information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Printed Patient's Name Date of Birth

_____

Responsible Party's Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of the receipt of our Notice of Privacy from this patient but it could not be obtained because:

❏ The patient refused to sign.

❏ Due to an emergency situation it was not possible to obtain an acknowledgement.

❏ We weren't able to communicate with the patient.

❏ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee Signature Date

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state laws

NORTHLAND FAMILY CARE, P.C.

Financial Policy

Effective 1/1/2018

We value our relationship with our patients. To make sure there are no misunderstandings, our office policies regarding financial responsibilities for services provided are outlined below. Please review these policies and ask us if you have any questions.

OUR RESPONSIBILITIES

- File primary insurance claims within a timely filing period following the date of service.
- File secondary insurance claims after the primary insurance payment is received.
- Provide information to your insurance company as requested.
- Contact the insurance carrier if the claim is not paid within 45 days after filing.
- Mail itemized statements to you.

YOUR RESPONSIBILITIES

- Present your insurance card and valid picture ID at the time of check-in to confirm correct insurance and billing information. If you do not have your insurance card at the time of check-in you will be considered a self-pay patient.
- Pay co-pays, deductibles and/or co-insurance at check-in by cash, check or credit card. A $20 administration fee will be charged if you do not.
- Verify that all requirements of your insurance plan are met. Two examples of this are (1) confirm with your insurance company that our providers are in network and (2) find out if approvals are needed for referrals.
- Respond immediately to insurance company correspondence concerning claims filed by Northland Family Care on your behalf.
- Contact your insurance company if your claim has not been paid, or if you have not received an explanation of benefits within 45 days.
- Pay all charges upon receipt of the initial statement.
- Call our billing department if you cannot pay your balance in full in 30 days.
- Notify us at least 24 hours in advance if you cannot keep your appointment. We will charge a $25 cancellation fee if you do not notify us at least 24 hours in advance.

ADDITIONAL POLICIES AND INFORMATION

- When treating a minor (person under the age of 18) the legal guardian must give consent for treating the minor. All other policies still apply.
- A $35 fee will be added to the amount of a check returned, regardless of the reason for the return.
- Any balances over 90 days old may, at our discretion, be turned over to a collection agency. If that occurs your account will become a self-pay account, meaning payment must be made at the time of service.
- Workers' Compensation Claims: We do not bill workers' compensation insurance. We do not treat conditions from open workers' compensation claims.
- Auto accidents: (1) All auto accidents will be self-pay appointments (2) We do not file insurance for auto accident claims and (3) we do not accept responsibility for collecting or negotiating insurance settlements. Treatment resulting from auto accident will be considered self-pay.

I have received and will abide by the above policies:

_____ _____

Patient Printed Name — Date of Birth

_____ _____

Patient Signature (if patient is a minor, responsible party please sign) — Today's Date

_____

Responsible Party Printed Name (if other than the patient)

Revised 12/29/2017

NORTHLAND FAMILY CARE, P.C.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____ / ____ / _____

Release of Information

❑ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ❑ Spouse _____
- ❑ Child(ren) _____
- ❑ Other _____

❑ Information is not to be released to anyone .

This Release of Information will remain in effect until terminated by me in writing or three (3) years after the date signed, whichever is first.

Messages

Please call ❑ my home ❑ my work ❑ my cell number: _____

If unable to reach me:

- ❑ you may leave a detailed message
- ❑ please leave a message asking me to return your call
- ❑ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____ / ____ / _____

Witness: _____ Date: ____ / ____ / _____