Harbour Towne Health PLLC

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Muskegon, MI 49444
Phone: 231.375.8065
Family Medicine Fax: 231.375.8063
Psychiatry/Counseling Fax: 231.375.8076

REGISTRATION FORM

(Please Print)

Today's date: | **Provider Preference:** ❑ Male ❑ Female ❑ Either

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Primary phone no.: ( )

City:	State:	ZIP Code:	Cell phone no.: ( )

Occupation of patient:	Employer/School Name of Patient:	Employer phone no.: ( )

Email:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for insurance coverage:	Birth date: / /	Address (if different):	Primary phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance ❑ Aetna ❑ BCBS ❑ Humana ❑ Medicaid of MI ❑ Medicare of MI
❑ Meridian Medicaid ❑ Molina ❑ Priority Health ❑ Priority Health Medicare ❑Wellcare ❑ Other (specify) ____________

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Primary phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize HARBOUR TOWNE HEALTH or insurance company to release any information required to process my claims.

X ______________________________ ______________________

Patient/Guardian signature *Date*

POLICIES

Please review, then sign and date at the bottom to acknowledge your understanding of the clinic policies of Harbour Towne Health.

- Co-pays are expected **at the time of service. If you are unable to make payment at the time of service, your appointment will be rescheduled.** We will submit claims to your insurance company as a courtesy; however, please know that you are responsible for ALL fees if your insurance does not cover our services for any reason. Insurance companies list coverage for psychiatrists' services under "Outpatient Mental Health." Please familiarize yourself with your policy benefits by calling the number on the back of your insurance card.
- Failure to pay on outstanding balances may result in discharge from our clinic.
- Keep and be on time for your appointments. This is your responsibility. **If you are more than 10 minutes late, you will be asked to reschedule. If you miss an appointment and do not call to cancel 24 hours prior, we may charge you a $50 cancellation fee.** This time has been reserved exclusively for you, and it is important to keep your scheduled appointment; this is not a penalty. We cannot bill your insurance for this fee. This payment must be made by you before you can be seen for another appointment.
- **Two consecutive no-shows or three no-shows within a rolling calendar year may result in discharge from our clinic.**
- Non-compliance with treatment may result in discharge from our clinic.
- Please be courteous to staff and fellow patients. Hostility will result in discharge.
- **MEDICATION REFILL REQUESTS REQUIRE 2 FULL BUSINESS DAYS TO PROCESS.** Sometimes an appointment is required for medication changes and/or refills.
- If your medication is not covered and your insurance requires a prior authorization, formulary exemption, tier or quantity exemption, please have your pharmacy fax us a request with your prescription plan information. NOTE: After we submit the necessary paperwork, the processing time will depend upon your insurance company.
- Please SILENCE YOUR CELL PHONE inside our clinic.
- This is an outpatient facility; there is no emergency/afterhours contact number. If you have an emergency, please call 911 or proceed to the nearest emergency room.

Family Medicine office hours are Monday, Tuesday & Thursday 8:30am-4:30pm and Wednesday & Friday 8:30am-2:30pm by appointment only.
Psychiatry office hours are Monday – Wednesday 8:00am-5:00pm, Thursday 8:00am-4:00pm and Friday 8:00-12:00pm. Counseling office hours are Monday-Thursday 8:00am-4:30pm and Friday 8:00am-3:30pm.
I acknowledge that I have read and understand the policies for Harbour Towne Health.

X

(Patient/Guardian Signature) (Printed Name)

Date:

Harbour Towne Health PLLC

CONSENT TO TREAT

All references to "patient", "me" and "my" in this document means:

______________________________________ ______________________

Name of patient Date of Birth

I have the legal right to consent to medical treatment because I am the patient, or I am the parent/guardian of the patient.

PLEASE INITIAL TO THE RIGHT OF EACH STATEMENT ACKNOWLEDGING YOUR UNDERSTANDING:

I acknowledge that I am voluntarily consenting to health assessment and/or treatment services. I have the following rights regarding services and may discuss these at any time with my health professional:

1. I can discuss any intervention being suggested as well as any questions I have concerning the course, purpose and direction of treatment (i.e. how the treatment will work).
2. I have the option to explore any other possible treatments or alternatives to psychotherapy.
3. I have the opportunity to discuss any possible risks, discomforts or side effects as well as any benefits that may occur in the course of treatment.
4. I have the right to withdraw from treatment at any time. (It is preferable to discuss this with my provider.)
5. If video or audio recording of sessions is to occur, this would require additional consent, for which a form will be provided. I have the right to refuse such additional consent.
6. Provider will talk about the limitations of privileged communications and confidentiality. Any questions I have will be answered.
7. I understand that there are no guarantees that can be promised regarding the outcome of treatment. I will be informed of what outcomes are possible.
8. I understand that in the event of an emergency, contact will be made with the appropriate parties on my behalf to protect myself or others.

Initial____________________

I understand by signing this form, I am giving permission to the doctors, physician assistants, nurse practitioners, counselors and other health care providers in this medical office to provide treatment as long as a provider/patient relationship exists, or until I withdraw my consent.

Initial ____________________