Harbour Towne Health PLLC
131 S. Seaway Drive, Suite 200
Muskegon, MI 49444
Phone: 231.375.8065
Fax: 231.375.8063

Patient Registration Form

****PLEASE FILL OUT COMPLETELY AND PLEASE PRINT NEATLY, THANK YOU!****

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	EMAIL

CHECK ONE: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

DATE OF BIRTH	AGE	SSN

EMPLOYER	DRIVERS LICENSE #

PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18 OR IF SOMEONE OTHER THAN YOURSELF IS THE INSURANCE POLICY HOLDER:

PARENT(S)/ GUARANTOR/ LEGAL GUARDIAN

NAME	

MAILING ADDRESS	

CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

DATE OF BIRTH	SOCIAL SECURITY NUMBER

EMPLOYER

EMERGENCY CONTACT PERSON	

RELATIONSHIP TO PATIENT	PHONE NUMBER

IS THIS A WORKER'S COMPENSATION CLAIM? YES NO

BY SIGNING BELOW, I HAVE READ AND UNDERSTAND THE FINANCIAL RESPONSIBILITY AND UNDERSTAND THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY SERVICES RENDERED.

CHECK ONE: PATIENT PARENT LEGAL GUARDIAN

SIGNATURE:	DATE:

PRIMARY INSURANCE INFO.

INSURANCE COMPANY

POLICY HOLDER NAME

DATE OF BIRTH

RELATIONSHIP TO PATIENT

POLICY NUMBER

GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY

POLICY HOLDER NAME

DATE OF BIRTH

RELATIONSHIP TO PATIENT

POLICY NUMBER

GROUP NUMBER

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General 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 ACKOWLEDGING YOUR UNDERSTANDING.

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

  Initial _____

- We share medical records electronically and in paper form with other health care providers to allow and promote continuity of care among providers. If you visit another provider in Harbour Towne Health's integrated group who also participates in electronic medical system, they may have access to your medical records.

  Initial _____

- As a service to our patients, Harbour Towne Health PLLC provides courtesy appointment reminder calls/text, emails and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls/text at the cell/home phone number you have provided to us.

  Initial _____

- I give permission to Harbour Towne Health PLLC Employees to release any medical records or demographic information to the follow entities:

Spouse: _____ Employer: _____

Other: _____

Initial _____

- I authorize Harbour Towne Health PLLC to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exists, or until I withdraw my consent.

  Initial _____

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

_____ _____
(Print Guardian's Name) (Relationship)

X_____ _____
(Signature of Patient/Guardian) (Date)

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Patient History Forms

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Hospitalizations/ER visits (include where, when, & for what reason):

Have you ever had diagnostic test (XR, CT, MRI) and any recent labs, If so where & when?

CURRENT MEDICATIONS		
Drug allergies: ❑ No ❑ Yes To what? Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth?
(specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?
Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____
Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:
Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

_____ _____

Print Guardian's Name **Relationship**

X_____ _____

Signature of Patient/Guardian **Date**

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)_____ _____ _____					Yes □ No □

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Harbour Towne Health PLLC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my minor child during the period of such medical care (valid one year from signature date) to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Harbour Towne Health PLLC. I understand that my medical insurance may pay less than the actual bill for services and I agree to be responsible for payment of all services provided to me or my dependents.

X_____ _____

Signature of Patient/Guardian Date

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Financial Policy

Thank you for choosing Harbour Towne Health PLLC – Family Medicine as your primary care provider. We are committed to providing you with quality and affordable healthcare. Just as we want you to be knowledgeable about your health care, we also want you to understand the financial policy of Harbour Towne Health PLLC – Family Medicine. Please understand that payment of your bill is considered a part of your treatment. The following is our Financial Policy, which we require to be read and sign.

Full payment of your copayment, deductible, and non-covered services are due at the time of service. We accept cash, check and most credit cards (Visa, MasterCard, Discover, American Express and Debit Cards)
Patient/Guarantor Demographic Information

To appropriately bill your insurance company, we will request the following information: current insurance card, current address and date of birth of the subscriber (it is your responsibility to keep your information up to date). If you choose not to provide us with your information, you will be considered self-pay and payment for your services will be expected at the time of your service.

Your driver's license will also be requested per The Red Flag Rule. For information regarding the Red Flag Rules, please refer to the Federal Registry at https://www.gpo.gov/fdsys/pkg/FR-2014-05-29/pdf/2014-12358.pdf
If we are unable to locate you for collecting debt, your account will be placed with an outside collection agency.

Divorce/Minor Children

Who is responsible for payment of services provided to minor children when the parents are divorced? According to the law, both parents are legally responsible.
Harbour Towne Health will not become engaged in a dispute for payment of these services, the parent who consents for treatment will be held legally responsible for payment of any services provided to the minor child.

Insurance

Harbour Towne Health PLLC participates with most insurance plans including Medicare, BCBS, BCN, ASR and Priority Health. Knowing your insurance benefits is a patient's responsibility. Please contact your insurance company with any questions that you may have regarding coverage.

Non-participating/Out of Network Insurances

If Harbour Towne Health PLLC do not participate with your insurance, you are responsible for full payment at the time of service for all services rendered. If you have out-of network benefits and your insurances sends a reimbursement check to you, it is your responsibility to sign it over to Harbour Towne Health PLLC, immediately. Failure to do so will lead to sending your account to collections.

Deductibles/Copayments & Non-covered Services

All copayments and deductibles must be paid at the time of service. This arrangement is part of your contact with your insurance company.

Missed/Cancelled Appointments

There will be a $25.00 charge for 15-minute appointments when you no-show or do not provide 24 hours notice for a cancellation. If you have a 30-minute appointment, the charge will be $50.00.

Examples of 15-minute appointments: Sick Visit, Follow-up, Well-Child Visits.
Examples of 30-minute appointments: Annual Physical Exam, New Patient Appointments, Procedures.

Three no-shows or late cancellations in a one year period could result in dismissal from the practice. We understand that life happens and we are generally understanding of some circumstances. Please respect our provider's time and give adequate time for us to fill your appointment slot if you are unable to make it.
If you are more than 10 minutes late for your appointment, we may request that you reschedule.

Refunds

If you have a patient credit on your account, it will be refunded to you within 90 days of the credit becoming due to you. If you are aware that you have a credit and wish to keep it on your account for future out of pocket expenses, please contact our office.

Patient Balances After Insurance

After your insurance company responds to your claim with either a payment or denial, the self-pay balance that will be billed is due upon receipt of your statement. All patient balances are due in full within 30 days after you receive your first statement.

Returned Checks

If we receive your check back from our bank indicating non-sufficient funds or closed account, there will be a charge of $30.00 to you to cover our bank fees. If you have 2 non-sufficient funds checks, you will be asked to pay by cash or credit card.

Bad Debt Accounts

If after 60 days, you fail to satisfy payment on your account and do not contact our billing department to make arrangements for payment; your account may be sent to a debt collector agency to collect debt on our behalf. If your account is placed in an outside collection agency, you will be notified by certified letter that you have been discharged from the practice and have 30 days to find a new physician. We will only provide urgent care to you during this 30 day transition period. A copy of your medical records will be forwarded to a physician of y our choice once a medical records release form is signed by you and sent to us. Please allow 30 days for your records to reach your new physician.

Form Fees

Harbour Towne Health PLLC will charge a fee of $25.00 for forms that need to be filled out by the provider unless you are scheduling an office visit to complete the form. If you are dropping off, mailing, or faxing forms for completion, you will be expected to pay this fee at the time of pick up.
Exceptions: If you have a form that your insurance company is requesting your provider to fill out (Healthy Blue Living for Blue Care Network or Health by Choice for Priority Health), we will not charge for completing these forms. However, if you have not been seen in the office by one of our providers within six (6) months, you will be required to be seen prior to the form being filled out and forwarded to your insurance company. If you request a copy of your medical records for your own personal use, there will be a fee assessed. There is no fee if copies of your records are forwarded to another physician per your request.

I further understand that part of the financial policy includes policies relating to unpaid copayments, "no showed" and "late cancel" appointments. I understand that Harbour Towne Health PLLC expects full payment, within 30 days, from me on patient balances after my insurance is billed and responds to my claim. If I am self pay (uninsured/no insurance), I understand that I am expected to pay my charges in full on the date the services are provided to me.

I have read this form or this form has been read to me in a language that I understand and I have had an opportunity to ask questions about it.

X _____ _____
Signature of patient (parent/guardian if a minor) Date

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AUTHORIZATION FOR RELEASE
MEDICAL INFORMATION AND RECORDS

PATIENT NAME: _____ _____ _____
LAST FIRST MI

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____
_____

DATE OF BIRTH _____ SSN# _____

I hereby authorize: _____ (provider/facility name)
_____ (address)
_____

Phone: _____ Fax: _____ **to release information from my medical records to HARBOUR TOWNE HEALTH PLLC for continuation of care.**

INFORMATION TO BE RELEASED: DATES:
□ History and physical exam _____
□ Progress notes _____
□ Lab reports _____
□ Imaging reports (X-rays,MRIs, CT) _____
□ Other: _____ _____
_____

I specifically authorize the release of medical information relating to:

□ **Substance abuse (including alcohol/drug abuse)**

□ **Medical health (including psychotherapy notes)**

□ **HIV related information (AIDS related information)**

□ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

This information may be disclosed and used by the following individual or organization:
Release to: HARBOUR TOWNE HEALTH PLLC
Address: 131 W SEAWAY DRIVE, SUITE 200, MUSKEGON, MI 49444
Fax: (231)375-8063 □ **Please fax records**
Phone: (231) 375-8065 □ Please mail records

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Medical Records Director and any information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. The released information may not be copied, shared or re-released , except as consistent with the authorized purpose above. I understand that I am not required to sign this authorization, and that HARBOUR TOWNE HEALTH PLLC/ HARBOUR TOWNE HEALTH PROVIDER will not refuse me treatment if I refuse to sign. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it. If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition:

X _____ _____
Signature of Patient or Legal Representative **Date**

X_____ _____
Harbour Towne Health PLLC Office Staff Signature **Date**