

DELTON MEDICAL CENTER

11320 S. M-43 Hwy, P.O. Box 675, Delton, MI 49046

Phone #: 269-623-5521 Fax #: 269-623-5527

Patient Name: _____ Date: _____

Address: _____
Street City State Zip

Home #: _____ Cell #: _____ SSN: _____

Date of Birth: _____ Gender: F / M Marital Status: S / M / D / W

Employer: _____ Phone #: _____

Address: _____
Street City State Zip

Emergency Contact: _____ Phone #: _____

Please list previous physicians/specialists and their locations: _____

Person responsible for charges (if other than patient): _____

Address: _____
Street City State Zip

Home #: _____ Cell #: _____ SSN: _____

Relationship to patient: _____ Occupation: _____

Employer: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Home #: _____ Cell #: _____

Signature: _____ Date: _____

I authorize treatment of the above patient. I am responsible to pay for all services received, regardless of insurance coverage.

Please provide insurance card(s) and driver's license or picture ID to the front desk for scanning.

DELTON MEDICAL CENTER

11320 S. M-43 HWY DELTON, MI 49046
Phone #: 269-623-5521 Fax #: 269-623-5527

Patient Authorization

I authorize the release of any medical or other information necessary to process any insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

I authorize payments of medical benefits to Delton Medical Center.

I am aware that there will be a charge of \$15.00 to my account for appointments not cancelled 24 hours in advance.

I authorize Delton Medical Center to contact me by phone number(s) provided.

I authorize, in my absence, for phone messages to be taken by an answering service, an answering machine or a responsible party answering the call, for the purpose of treatment, payment or health care issues.

Patient Name (Printed)

Patient Signature

Date

Witness Signature

Date

DELTON MEDICAL CENTER

11320 S. M-43 HWY DELTON, MI 49046
Phone #: 269-623-5521 Fax #: 269-623-5527

Notice

Delton Medical Center (DMC) is closed to accepting any new Health Plan of Michigan (HPOM), Medicaid or any other Chapter #19 entitlement program patients. Our position to close enrollment in these programs has been discussed with the appropriate representative at HPOM and Medicaid and is effective immediately.

It is further understood that patients who present to DMC as self pay and misrepresent their coverage with the intention of presenting eligibility under any of the above noted programs at a future appointment will be discharged from our practice.

This document will be included in the new patient packet and patients will be required to sign below which denotes their understanding of this policy.

Patient Name (Printed)

Patient Signature

Date

Witness Signature

Date

DELTON MEDICAL CENTER

11320 S. M-43 HWY DELTON, MI 49046
Phone #: 269-623-5521 Fax #: 269-623-5527

Notice of Privacy Practices Acknowledgement

The Notice of Privacy Practices for Delton Medical Center is located in a binder, identified as "Notice of Privacy Practices", in the reception area of the office. The receptionist will provide the Notice of Privacy Practices to all patients requesting a copy.

Questions regarding the content of the Notice of Privacy Practices should be directed to the Privacy Officer.

This signed document serves as an acknowledgement of the location of the Notice of Privacy Practices within our office for your review, and your ability to obtain a copy of the notice, by request.

Patient Name (Printed)

Patient Signature

Date

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Delton Medical Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Delton Medical Center)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Delton Medical Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Delton Medical Center, Attn: Privacy Officer, 11320 S. M-43 HWY, P.O. Box 675, Delton, MI 49046.

With this consent, Delton Medical Center may call my home or other alternative location and leave a message on voice mail, with a responsible party who answers the phone or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Delton Medical Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

With this consent, Delton Medical Center may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Delton Medical Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Delton Medical Center to use and disclose my PHI to carry out TPO.

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, or later revoke it, Delton Medical Center may decline to provide treatment to me.

_____	_____
Patient Name (Printed)	Name of Legal Guardian, if applicable
_____	_____
Signature of Patient or Legal Guardian	Date
	Relationship to Patient

Patient/Guardian may be provided with a signed copy of this authorization form.