Professional Village Medical Center
13700 19 Mile Road
Sterling Heights, MI 48313
P: (586) 247-6020
F: (586) 247-7048

Please read and complete ALL following information and return to the front desk, along with your insurance card and picture ID. Thank You!

Date: _____ **Name:** _____
First Middle Last

Date of Birth: _____ **Referred By:** _____
(internet, yellow pages, hospital, friend/family, etc.)

Sex: Male Female **Height:** _____

Marital Status:_____ **Spouse Name:** _____

If Child, List Parent's Names: _____

Address: _____ **City:** _____

Zip Code: _____ **Social Security Number:** _____

Home Phone: _____**Cell Phone:** _____

Work Phone:_____ **Employer:** _____

Driver's License Number:_____ **Emergency Phone:**_____

Emergency Contact (Name and Relation): _____

Type of Insurance: _____

Subscriber to Insurance: _____

Relationship of Subscriber to Patient: _____

Subscriber's Date of Birth: _____

Subscribers Social Security Number: _____

E-Mail Address: _____

Pharmacy Information

We have the ability to electronically send your prescriptions to your pharmacy. Please list your pharmacy information below

Name of Local Pharmacy: _____

Phone Number: _____

Approximate Location of Pharmacy: _____

_____

Name of Mail Away Pharmacy (if applicable): _____

Phone Number: _____

Address to Mail Away Pharmacy: _____

_____

If there is anything else we need to know in regards to your pharmacies or prescription coverage, please notify here:

- Do you have any records you would like transferred to our office? If so, please download our Record's Release/Request Form and bring with you to your appointment.

- Is there a spouse, family member, or other person you would like to make your medical records available to? If so, please download our Designation of Personal Representative Form and bring it with you to your appointment.

- Do you have advance directives or a living will? If so, please bring a copy with you to your appointment. If you do not have a living will, we would advise that you would consider having one made for your end of life decisions. You can contact your local hospital or lawyer for the appropriate paperwork. We also have some information in office that may help you.

Authorization and Agreements for Medical Treatment and Service

Consent for Treatment: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered as advisable or necessary in the judgment of the physician.

Agreement to Pay for Services: Regarding treatment and medical services rendered to the patient, I agree to pay for all services. I understand and agree that upon receiving notification of balances that payment will be made promptly. I also understand that upon failure to pay for these services, a 1.5% fee may be added monthly to any account greater than sixty days. A commensurate fee may be added and sent to an agency for collection proceedings. I promise to pay for services rendered to, or on behalf of the patient.

Release of Information: I hereby authorize Professional Village Medical Center to release any information to my insurance company in the course of my exam or treatment if it becomes needed to process the insurance claim.

Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to John S. DeMare, D.O., P.C. / Professional Village Medical Center. I am financially responsible for all non-covered and/or disallowed services.

Insurance Information: I understand that due to constant changes in insurance benefits, we are unable to maintain current coverage information on every patient's policy. If a physician who is not a participant with my specific insurance plan sees me, I may be responsible for any costs incurred. If a test is rejected due to patient's failure to notify the office of special insurance requirements, I may also be responsible for payment. I realize that it is my responsibility as the patient to be fully aware of my benefits such as hospital precertification, prior authorizations, second opinions, deductibles, co-pays, and laboratory coverage. I also realize that there may be insurance-billed charges that will not be reflected on my super-bill.

Medical Testing and Results: I understand that it is ultimately the patient's responsibility to contact this office for all testing, appointments, and the results of all tests performed on the patient.

I HAVE READ ALL OF THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS AND FULLY UNDERSTAND:

_____

Full Name **Date of Birth**

_____

Signature **Date**

_____

Relationship to Patient (if personal representative and/or patient is a minor)

HIPPA LAW

Notice and Acknowledgement

I acknowledge that I am aware of HIPPA privacy practices. Upon request, a copy can be obtained in our office.

_____

Patient Signature (or Personal Rep.) **Date**

If personal representative, please list relationship to patient: _____