Professional Village Medical Center
13700 19 Mile Road, Sterling Heights, MI 48313
Phone: (586) 247-6020 eFax: (586) 737-2338

Please read and complete ALL of the following information - Thank you!

General Patient Information

Today's Date:			
Last Name:	**First Name:**	**MI:**	
Date of Birth:	**Sex:** Male Female	**Social Security Number:**	**Marital Status & Spouse Name (if applicable):**
***If Minor, Responsible Parent's Name (Guarantor):	***Guarantor's Date of Birth:	***Guarantor's Social Security Number:	
Address:	**Apt #:**	**City & State:**	**Zip Code:**
Primary Phone Number: Home Cell Work		**Secondary Phone Number:** Home Cell Work	
Employer:		**Email Address:**	

Emergency Contact Information

Emergency Contact Name & Relation to Patient:	**Emergency Contact Phone Number:**

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name:	**Insurance Company Name:**
Subscriber to Insurance:	**Subscriber to Insurance:**
Subscriber's Date of Birth & Social Security Number:	**Subscriber's Date of Birth & Social Security Number:**
Relationship of Patient to Subscriber: Self Spouse Child Other	**Relationship of Patient to Subscriber:** Self Spouse Child Other

How did you hear about us? (please cirlce your answer):

Internet Word of Mouth Hospital Another Doctor Insurance

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.

Intials:_____

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.

Intials:_____

If my copay is not paid at time of service a $10 fee will be added to my account. If I fail to keep a scheduled appointment I will be charged the following amounts: $60 for non-routine visits and $100 for routine visits. If I am charged for these amounts I understand that these will also become my responsibility and may be sent to the collection agency for payment along with any unpaid balances.

Intials:_____

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.

Intials:_____

Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to John S. DeMare DO PC (d/b/a Professional Village Medical Center). I am financially responsible for all non-covered and/or disallowed services.

Intials:_____

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 bill.

Intials:_____

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

Intials:_____

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

Patient's Full Name (Printed):	**Date of Birth:**
Signature:	**Today's Date:**
Relationship to Patient (if patient is a minor or if personal representative is signing):	

HIPAA LAW

Notice and Acknowledgement

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

Patient's Full Name (Printed):	**Date of Birth:**
Signature:	**Today's Date:**
Relationship to Patient (if patient is a minor or if personal representative is signing):	

Is there a spouse, family member, or other person you would like us to be able to discuss your records / protected health information with?

If YES, please ask for a "Personal Representation Form".

(Information will not be given to any spouse, family member, or other person without this form signed as outlined by HIPAA.)