AS MEDICAL GROUP

MADISON HEIGHTS URGENT CARE

32600 JOHN R RD. MADISON HEIGHTS, MI 48071
Office Phone: 248.307.7796
Office Fax: 248.307.7801

NEW PATIENT INFORMATION FORM

Section I: Patient Information:

Last Name: _____ MI: _____ First Name: _____

Date of Birth: _____ SSN: _____ Sex: _____ Marital Status: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Drivers License/ State ID Number: _____ Primary Language: _____

Phone Number: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Primary Care Physician & Contact Info: _____

Preferred Pharmacy: _____

Medical Alerts: _____ Allergies: _____

Section II: Insurance Information:

Primary Health Insurance Name/ Type: _____ ☐ State Funded ☐ Paid For

Group Number: _____ Policy Number: _____

Secondary Health Insurance Name/ Type: _____ ☐ State Funded ☐ Paid For

Group Number: _____ Policy Number: _____

☐ If Same as Above Please Check Box

Insurance Card Holder Name (Last, MI, First): _____

Insured's Date of Birth: _____ Insured's Gender: _____

Insured's Street Address: _____ City: _____ State: _____ Zip: ____

Insured's SSN: _____ Insured's Phone Number: _____

Insured's Relationship to the Patient: _____

By consenting below, I authorize the release of any medical information necessary to process insurance claims and request payment of benefits to the party who participates.

Signature: _____ Date: _____

I understand the providers charge may exceed the insurance payments, and if greater than such payment, I will be responsible for that amount.

Signature: _____ Date: _____

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PATIENT RECORD OF DISCLOSURE AGREEMENT

With My Consent:

AS Medical Group Madison Heights Urgent Care, PLC, their staff and associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the AS Medical Group Madison Heights Urgent Care, PLC notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the notice of privacy practice prior to signing this consent. AS Medical Group Madison Heights Urgent Care, PLC 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 AS Medical Group Madison Heights Urgent Care PLC, 32600 John R Rd, Madison Heights, Michigan 48071.

With my consent, AS Medical Group Madison Heights Urgent Care PLC, their staff and associates may call my home or other designated location and solicit information related to medical operations or marketing material supplementing my care, as well as 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 (i.e. laboratory results and other ancillary services).

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

The practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement.

By signing this form, I am consenting to AS Medical Group Madison Heights Urgent Care, PLC's patient record of disclosure agreement and notice of privacy practices for use and disclosure of 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, AS Medical Group Madison Heights Urgent Care, PLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____ Printed Name of Patient or Guardian _____ Date _____

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PERMISSION TO TREAT

With My Consent:

I hereby give permission to Dr. Ali Shukr, MD or any designated healthcare professional of AS Medical Group Madison Heights Urgent Care, PLC to examine and treat me for medical conditions and as necessary.

I hereby assign all medical benefits including major medical benefits to which I am entitled, including Medicare, private and any other health plans to AS Medical Group Madison Heights Urgent Care, PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I understand that I am financially responsible for all the charges whether or not paid by set insurance. I hereby authorize said assignees to release all information necessary to secure payment from said insurance company**.**

_____ _____ _____

Signature of Patient or Legal Guardian Printed Name of Patient or Guardian Date

I hereby give permission as a parent or legal guardian for _____to be examined and treated by Dr. Ali Shukr or any designated health care professional as necessary today in on future visits.

_____ _____ _____

Signature of Patient or Legal Guardian Printed Name of Patient or Guardian Date

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PATIENT TREATMENT CONTRACT

#

PATIENT NAME _____ DOB _____ DATE OF SERVICE _____

As a participant in primary, urgent care or pain treatment, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disrupted activities in the doctor's office.
6. I understand that if dealing, stealing, or any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without recourse for appeal.
7. I agree that the medication/prescription can only be given to me at my regular office visit. A missed visit may result in my being unable to get my medication/prescription until my next scheduled visit.
8. I agree that the medication I received is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any other doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I also recognize that several deaths have occurred among persons mixing medications and benzodiazepine. (Especially if taken outside the care of a physician, using routes of administration other than oral or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand the medication alone is not sufficient treatment for my condition and I agree to participate in additional recommended treatment as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level and random pill counts per the doctor's discretion.
15. I understand that violations of the above may be grounds for termination of treatment.

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_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Patient or Guardian | Date

PATIENT PAST MEDICAL HISTORY

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Last Name: _____ **MI:** _____ **First Name:** _____

Marital Status: _____ **Sex:** _____ **Date of Birth:** _____

Race/Ethnicity: _____

Significant medical diseases/conditions:

1.) Grandparents, parents, siblings, children or relatives with the following conditions?

_____

□ HTN, □ HEART DISEASE, □ STROKE, □ LUNG DISEASE, □ DM, □ CANCER, □ OBESITY, □ DEPRESSION, □ DEMENTIA

Psychiatric diseases/conditions:

1.) Over the past 2 weeks have you often been bothered by feeling down, depressed or hopeless? _____

2.) Over the past 2 weeks, have you often been bothered by little or no pleasure in doing things? _____

All current medications: (Please include dosage, frequency, indication, effectiveness, and side-effects)

_____

_____

_____

Previous allergies:

1.) Allergy _____**, specific reaction that occurred**_____**, □ check if medication**

2.) Allergy _____**, specific reaction that occurred**_____**, □ check if medication**

3.) Allergy _____**, specific reaction that occurred**_____**, □ check if medication**

Previous hospitalizations & surgeries:

1.) Reason _____ **date of hospitalization** _____

2.) Reason _____ **date of hospitalization** _____

3.) Reason _____ **date of hospitalization** _____

Female menstrual history:

Age of onset_____**, current problems**_____

Menopause (age of onset, current problems) _____

Pregnancies (number, outcomes) _____

Patient preventive/screening practices:

Female: □ pap smears, □ mammograms.

50+: □ colon cancer screening (fecal occult blood testing or colonoscopy)

Immunization status:

For adult patients: □ tetanus, □ hepatitis b and □ influenza

For chronic illness or geriatric (>65 years old) patients: □ pneumonia or □ shingles vaccines