INFINITY PRIMARY CARE

Registration Form

(PLEASE PRINT with Blue or Black Ink)

Physician:_________________________________

Name ___________________________________ Birthdate ___________ Sex ________ SS# _________________

Address ______________________________________ City _________________ State ______ Zip _____________

Race:________________________ Ethnicity:__________________ Preferred Language:______________________

Please circle: Married Single Widowed Divorced Domestic Partner Legally Separated Life Partner

Primary Phone: _____________________ Home Cell Work Other:_____________

Secondary Phone: ___________________ Home Cell Work Other:_____________

Tertiary Phone: _____________________ Home Cell Work Other:_____________

Email Address____

INSURANCE INFORMATION

Please provide your identification and your insurance card(s) to be copied. If your insurance information is not provided within 24 hours, you will be billed for the services rendered.

1st Insurance Co. Name ________________________ Group number: ___________ Policy Number:______________

Policy Holder Name __________________________ Birthdate _______________ Relation to patient:_____________

2nd Insurance Co. Name ________________________ Group number: ___________ Policy Number:______________

Policy Holder Name __________________________ Birthdate _______________ Relation to patient:_____________

EMERGENCY CONTACT

Name ____ Relationship _________________________________

Primary Phone: _____________________ Home Cell Work Other:_____________

Secondary Phone: ___________________ Home Cell Work Other:_____________

I authorize the release of medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to my child. I permit a copy of this authorization to be used in place of the original.
I understand I am responsible for any charges incurred that are not covered by my insurance company.
I have read this information and understand it. I understand that I am responsible for my insurance co-pay at time of visit.

The above information is correct to the best of my knowledge.

____ ___________________

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

INFINITY PRIMARY CARE

GENERAL CONSENT FOR TREATMENT

Patient Name_________________________________Birthdate:__________________Physician:____________________

1. CONSENT: I request and authorize inpatient, emergency, and/or outpatient care as my physician, and his/her designees and assistants may deem necessary or advisable. This includes, but is not limited to, routine diagnostic, radiology, and laboratory procedures, administration of routine drugs and other therapeutics, and routine medical, nursing, and hospital care.

2. MINORS: A patient under 18 years of age must have authorization for treatment signed by a parent or legal guardian. Minors with decision-making capacity have the right to participate in discussions regarding their care and obtain answers to their questions about their condition and treatment.
EXCEPTIONS: Minors do not require consent from their parent/guardian in the following instances:

a. Minor is married.
b. Minor is in the Armed Forces.
c. Minor is emancipated by court order
d. Minor who has/is receiving prenatal or pregnancy related care, substance abuse, psychiatric treatment, or treatment for HIV or sexually transmitted diseases.
e. A minor may consent to the release of their own child(ren)'s records.

3. NO GUARANTEES: I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have authorized. I understand I have a responsibility to cooperate in my care.

4. PATIENT RESPONSIBILITIES: I understand and agree that it is my responsibility to:

- Schedule follow up appointments and tests ordered by my physician.
- Provide a minimum of 24 hour notice of cancellation or to reschedule an appointment if needed.
- Call the office if I am unable to keep an appointment for any reason.
- Pay all charges not covered by my insurance company including:
    - Deductibles
    - Copays
    - Non-covered services
    - Pay all charges for services rendered despite any disputes or disagreements between myself and my insurance company.

5. PAYMENT: I assign and authorize payment for any and all services rendered directly to Infinity Primary Care, PLLC from my insurance company or third party payor, including but not limited to Medicare, Medicaid, commercial health insurance, automobile no-fault insurance, and workers disability compensation insurance.

6. RELEASE OF INFORMATION: I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Infinity Primary Care, PLLC to release all information from my medical record, including information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis (if any), and substance abuse treatment information protected by 42 code of Federal Regulations Part 2 (if any):

a. Providers to which I am referred and will receive treatment for the purpose of continuity of care;
b. Payors, organizations, or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my hospital and/or physician(s) bill, and for filing appeals of denial of benefits, so that the hospital and physician may be paid for the services provided to me; and

c. Independent auditors or review agencies retained by any third party payors and insurer to analyze the charges for services rendered to me.

This authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. This authorization may be revoked at any time, except to the extent that it has been relied on.

I understand that Infinity Primary Care, PLLC may perform a test for HIV or Hepatitis upon me without my written consent, as permitted by state law, if a health care worker or emergency first responder sustains an exposure to my blood or body fluids. The results of any test will be treated confidentially.

7. VALUABLES: I understand that Infinity Primary Care, PLLC is not responsible for clothing, eyeglasses, dentures, jewelry, money, or other personal articles kept in my possession. I release Infinity Primary Care, PLLC from responsibility for all personal articles which I have with me during the time I am a patient at the physician office of medical facility.

8. TEACHING INSTITUTION: I have been informed that Infinity Primary Care, PLLC participates with teaching institutions, and that my medical, surgical, nursing, and routine health may be observed and provided for by supervised resident physicians and/or health care students. I authorize such clinical students to observe and provide this care. I also understand that my treatment and medical records may be viewed by approved students and staff for teaching, study, and research purposes, and the confidentiality of my identity shall be protected. I may request that a clinical student not be involved in my care.

I have read both pages of this consent form or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

____ ____________________

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

____ ____________________

Infinity Primary Care Staff Date

INFINITY PRIMARY CARE

PATIENT FINANCIAL RESPONSIBILITY

Patient Name________________________________Birthdate:_________________Physician:___________________

Thank you for choosing Infinity Primary Care, PLLC as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Patient Financial Responsibility Policy, which we require you to read and sign prior to seeing the physician. Please let us know if you have any questions or concerns.

For your convenience we accept cash, check, Visa, MasterCard, American Express, and Discover.

I understand I am financially responsible for treatment provided to me or my legal dependent by Infinity Primary Care, PLLC.

I understand my insurance policy is a contract solely between me and my insurance company. I understand that, as a courtesy, my physician will submit a claim to my insurance plan. I authorize my insurance plan to make payments for covered services directly to my physician.

If my physician does not participate with my insurance company, or if my insurance company has not paid the claim within 45 days, I understand the balance becomes my responsibility and I must pursue the reimbursement directly from my insurance company. If there is a balance on my account, a statement of my charges and payment will be sent to my mailing address.

I authorize Infinity Primary Care, PLLC to communicate with my health insurance company, in accordance with their Privacy Policy, regarding my policy coverage. I further authorize Infinity Primary Care, PLLC to release information required by my insurance company to make payment for services rendered.

I understand a payment plan may be set up if I have financial difficulties. Charges over 90 days past due without a payment plan may be sent to a collection agency and may result in being discharged from the practice.

I understand there can be a $10.00 late fee for accounts over 60 days past due. I understand there can be a $30.00 fee for returned personal checks.

I understand appointment cancellations with less than 24 hour notice or “No Show” patients can be charged a service fee of up to $25.00 for missed office visit or up to $50.00 for missed physical exam or procedure. I understand I am responsible for this fee. I understand it cannot be billed to my insurance plan.

I have read the Patient Financial Policy and understand my responsibilities.

____ __________________

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

____ __________________

Infinity Primary Care Staff Date

INFINITY PRIMARY CARE

LAB BILLING NOTIFICATION

Patient Name_________________________________Birthdate:__________________Physician:____________________

Insurance policies are changing and may no longer cover certain lab tests. Many are now subject to copays and deductibles. If you are here for a Physical Exam but have a medical condition that requires lab testing, the lab tests for that condition will be coded with that medical condition (not the Physical Exam)

Lab tests are ordered by our providers because they are medically necessary and sometimes because they are specifically requested by you.

We are NOT familiar with, nor do we have access to each individual patient's insurance policy with regard to payment for lab tests. It is the patient's responsibility to be familiar with their specific insurance plan with regard to payment for lab tests.

Some insurance companies require that your lab tests be sent to specific labs such as JVHL, Quest, or St John. It is your responsibility to notify your medical assistant about this PRIOR to having your lab tests drawn.

If you receive a lab bill and have questions about coverage, review the following PRIOR to calling us (we have limited ability to review laboratory claims)

- Review your insurance policy
- Review the Explanation of Benefits from your insurance company
- Contact your insurance and/or the laboratory that is sending the bill
- IF you still need to contact us, have your bill and Explanation of Benefits from your insurance company available when you call.

____ ____________________

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

____ ____________________

Infinity Primary Care Staff Date

Credit Card Signature on File Authorization Form

All credit card information will remain confidential and will not be released to any unauthorized party.

At any given visit you may choose to pay by cash or check or defer to the credit card on file.

We have implemented a policy which maintains your credit card information securely on file with Infinity Primary Care, PLLC. You will be asked for a credit card at the time you check-in.

In providing us with your credit card information, you are giving Infinity Primary Care, PLLC permission to automatically charge your credit card on file to pay co-pays, deductibles and balances you owe after your insurance company has paid their portion and notified us of the amount that is your responsibility. **You will receive a statement that will indicate the amount due and we will deduct that amount from your card 10 days later.** At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you upon request. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I hereby authorize Infinity Primary Care, PLLC to charge the credit card provided on an as needed basis for the amount(s) due for service(s) that are the patient responsibility amounts as determined by my insurance. I further authorize that any time my account becomes past due Infinity may use this card to settle the debts owed on my behalf. Any overpayment on my account will be credited back to my card. My credit card statement will serve as receipts for payments processed. You may request a copy of your receipt through your patient portal.

This document designates my Signature is on File and therefore it is not required that I sign paper receipts each time. This authorization is to remain in effect until Infinity Primary Care receives written notification from me of its termination. If my bank account or credit card information listed below changes for any reason, I will notify Infinity Primary Care, PLLC as soon as possible.

____

(Signature) Date:

Print Patient Name: ______________________

Date of Birth_______/_______/_______

If you think your charges are incorrect, please contact the Infinity Business Office with an explanation of the problem. We will make any necessary adjustments to your account within 30 days. After 60 days all charges will be assumed to be correct. Contact information: 734-464-8300.

Revised: 01/04/2016

Communicate with us securely ONLINE

The "**Patient Portal**" is a service we provide to our patients that integrates with our electronic medical record and provides more efficient service to you.

THE PATIENT PORTAL SHOULD ONLY BE UTILIZED FOR ROUTINE MATTERS AND SHOULD **NOT** BE UTILIZED FOR URGENT ISSUES.

Services that are available in the "**Patient Portal**":

- Request medication refills
- Receive test results
- Request referrals to specialists
- Instant access to your medical records
- Ask your physician a question
- View or cancel upcoming appointments

The "Cancelling" feature does work up to 24 hours in advance of your appointment. Appointments that need to be cancelled within 24 hours of their appointment time are subject to a Late Cancellation Fee and need to be called in to the office.

Access the Patient Portal at www.NextMD.com or www.infinityprimarycare.com (choose the NextMD or Patient Portal link).

……………………………………………………………………………………………………

Complete the information listed below and give this form to any associate. Once this form is received, you will be given a security token that will be needed to create your portal account.

PRINT CLEARLY

Patient's First Name: ________________________ Patient's Last Name: ___________________

Patient's Birth Date: _________________________

Patient's CURRENT Email address: ____

NOTE: Protecting the security of your medical record is important to us. We will not create Patient Portal access over the phone or with anyone other than the patient or a parent/guardian of minor children.

INFINITY PRIMARY CARE

INFINITY PRIMARY CARE
ADULT HISTORY FORM
PLEASE PRINT
(with Blue or Black Ink)

Today's Date:____________
Physician:__________________

Name: (last) __________________________________ (first) ____________________________ Date of Birth: __________________
Mail Order Pharmacy:______________________________ Phone:___________________________ Fax:________________________
Local Pharmacy:___________________________________ Phone:___________________________ Fax:________________________
Language Spoken at home:_________________________

MEDICATIONS:
Please list all medications (include over-the-counter?)
In preparation for your visit bring all medications, inhalers, vitamin or supplements in their original bottles.

NAME STRENGTH FREQUENCY

1.____

2. ____

3.____

4.____

5.____

6. ____

7.____

ALLERGIES:
Are you allergic to any drugs or medications?
NO YES If yes, what?

Do you have any food allergies?
NO YES If yes, what?

Any other allergies?

NO YES If yes, what?

PAIN:
Are you having pain today? NO YES
If yes, on a scale of 1-10
1 =little or no pain and 10 = severe pain
What level are you at? __________

REVIEW OF SYSTEMS: Please check any symptoms you have had RECENTLY

Constitutional
O Chills
O Fatigue
O Fever
O Night sweats
O Weight gain
O Weight loss

HEENT
O Ear drainage
O Ear pain
O Eye discharge
O Eye pain
O Hearing loss
O Nasal drainage
O Sinus pressure
O Sore throat
O Visual changes

Respiratory
O Cough
O Shortness of breath
O Wheezing

Cardiovascular
O Chest pain
O Leg pain when walking
O Edema (swelling)
O Palpitations

Gastrointestinal
O Abdominal pain
O Blood in stool
O Change in stool
O Constipation
O Diarrhea
O Heartburn
O Loss of appetite
O Nausea
O Vomiting

Genitourinary
O Painful urination
O Blood in urine
O Urinary frequency
O Urinary incontinence

Skin
O Hair loss
O Hives
O Itching
O Mole changes
O Rash
O Skin lesion

(Female Only)
O Breast discharge
O Breast lump
O Breast pain

Reproduction
(Female Only)
O Abnormal Pap
O Painful period
O Painful intercourse
O Hot flashes
O Irregular menses
O Vaginal discharge

Last Period________

(Male Only)
O Erectile dysfunction
O Penile discharge

Neurological
O Dizziness
O Extremity numbness
O Extremity weakness
O Gait disturbance
O Headache
O Memory loss
O Seizures
O Tremors

Psychiatric
O Anxiety
O Depression
O Insomnia

Metabolic/Endocrine
O Cold intolerance
O Heat intolerance
O Excessive thirst
O Excessive hunger

Musculoskeletal
O Back pain
O Joint pain
O Joint swelling
O Muscle weakness
O Neck pain

Hematologic/Lymphatic
O Easy bleeding
O Easy bruising
O Enlarged lymph nodes

Immunologic
O Contact allergy
O Environmental allergies
O Food allergies
O Seasonal allergies

Name: ________________________________ DOB:___________________

In the last 2 weeks have you felt down, depressed or hopeless? (circle one)

Not at all   Several Days   More than ½ the days   Every Day

Had little or no interest in doing things? (circle one)

Not at all   Several Days   More than ½ the days   Every Day

CHRONIC CONDITIONS: Please mark any illness or disease you have had in the past or currently have:

O Allergies	O Coronary artery disease	O Kidney disease	Other-Specify______________
O Anemia	O Depression	O Seizure disorder	O Glaucoma
O Angina	O Diabetes	O Stroke	O Macular Degeneration
O Anxiety	O High cholesterol	O Thyroid disease	O Eye Problems
O Arthritis	O Gall bladder disease		O Head Injury
Specify_________________	O GERD		O Congestive Heart Failure
O Asthma	O Headache, migraine		O Neck/Back Problems
O Atrial Fibrillation	O Heart disease		O Hiatal Hernia
O Benign prostatic hypertrophy	O Heart valve disorder		O Stomach Ulcers
O Blood clots	O Hepatitis/liver disease		O Bladder Problems
O Cancer	O High Blood Pressure		O Gout
Type___________________	O Irritable bowel syndrome		O Chronic Insomnia
O Cardiac arrhythmia	O Heart Attack		O Psychiatric Illness
O COPD/Emphysema	O Osteoporosis		

SURGICAL/HOSPITALIZATION HISTORY: (if marking an item below please include the year it occurred)

O Angioplasty	O Cataract Extraction	O LASIK	O Other______________
O Appendectomy	O Gall Bladder Removal	O Mastectomy	O Bladder suspension
O Arthroscopy	O Colectomy	O Myomectomy	O Cervix Surgery
O Back Surgery	O Colostomy	O ORIF (Fracture surgery)	O Liver Biopsy
O Bilateral Tubal Ligation	O D and C	O Thyroidectomy	O Prostate Biopsy/Surgery
O Blood transfusion	O Gastric Bypass	O Tonsillectomy	O Vasectomy
O Breast Augmentation	O Hernia Repair		O Breast Reduction
O CABG (Bypass surgery)	O Hip Replacement		O Breast Biopsy
O Pacemaker	O Hysterectomy		
O Carpal Tunnel Release	O Knee Replacement		

What diagnostic, screening studies or immunizations have you had done previously? Please list most recent date.

Complete Physical	___________	Last PAP	___________	Tetanus/Td/Tdap Vaccine	___________
Cardiac Stress Test	___________	Last Mammogram	___________	Pneumonia Vaccine	___________
Colonoscopy	___________	Bone Density (DEXA)	___________	Zostavax/Shingles Vaccine	___________
Cholesterol	___________	Have you had the chicken pox?	_______	Hepatitis A Vaccine	___________
Last Eye Exam	___________	Flu Vaccine	___________	Hepatitis B Vaccine	___________
Last Dental Exam	___________				

Name: ______________________________ DOB:__________________

FAMILY HISTORY: **Check below to report problems your family members have had. Please state age when they had the problem if you know it.**

Adopted (unknown family history)

	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Sister	Brother	Child
ADD/ADHD									
Alcoholism									
Alzheimer's disease									
Arthritis (Rheumatoid)									
Asthma									
Blood disorder /Clotting									
Cancer (list type)									
Heart Disease									
Depression									
Diabetes									
Genetic disease									
High Blood Pressure									
Inflammatory Bowel Syndrome									
Mental Illness									
Migraines									
Obesity									
Osteoporosis									
Seizure disorder									
Stroke									
Thyroid disorder									
Aneurysm									
Elevated Cholesterol									
Other									
Deceased? Age?									

Name: ________________________________ DOB:___________________

SOCIAL HISTORY:

Tobacco Usage: No Yes Quit Type?____________If yes or quit, how long? _________ Packs per day? _________

Alcohol Usage: No Yes Quit Type? _________________ How Much? ____________

Caffeine Usage: No Yes Quit Type? _________________ How Much? ____________

Drug Usage: No Yes Quit Type? _________________ How Much? ____________

Occupation:________________________ Employed?____ Employer______________________

Military Experience: No Yes Current status: active reserves discharged retired military

Marital Status: Married Single Life Partner Divorced Widowed If married, spouses name: _________________

Do you have any children? ☐ No ☐ Yes

# of sons	________	# of daughters	________
# of stepsons	________	# of stepdaughters	________
# of adopted sons	________	#of adopted daughters	________

What is your activity level? Moderate Sedentary Vigorous

Exercise Type: _________________________Frequency? 2-3 times/week 3-4 times/week daily never occasional

Do you have a religious affiliation? ☐ No ☐ Yes Affiliation:_______________________

Smoke Detectors in home? ☐ No ☐ Yes Do you wear seat belts? ☐ No ☐ Yes

Carbon Monoxide Detectors in home? ☐ No ☐ Yes Firearms at home? ☐ No ☐ Yes

Radon in home? ☐ No ☐ Yes ☐ Treated ☐ Untreated

Are you sexually active? No Yes Not currently

Please list all specialty Physicians that you have seen in the last year:

Provider Name: ____________________________________
Specialty: ____________________________________
Phone Number: ____________________________________
Reason/Diagnosis: ____________________________________

Provider Name: ____________________________________
Specialty: ____________________________________
Phone Number: ____________________________________
Reason/Diagnosis: ____________________________________

Provider Name: ____________________________________
Specialty: ____________________________________
Phone Number: ____________________________________
Reason/Diagnosis: ____________________________________

Provider Name: ____________________________________
Specialty: ____________________________________
Phone Number: ____________________________________
Reason/Diagnosis: ____________________________________

The above information is correct to the best of my knowledge.

____ ________________________

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date