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 the Guarantor,_____, is 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 or 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

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.

I understand **all copayments, co-insurance and past due balances are due and payable at the time of service** (in some circumstance payment plans can be set up after a 25% minimum is paid). For your convenience, we accept cash, check, Visa, MasterCard, American Express, and Discover. We even accept HSA (health saving account) cards. We also offer a CCOF (Credit Card on file) program (ask staff for details).

I understand I am financially responsible for treatment provided to me or my legal dependent by Infinity Primary Care, PLLC. This includes physicals, office visits, procedures, lab or diagnostic testing ordered by my physician.

I understand my insurance policy is a contract solely between me and my insurance company. It is my responsibility to know if my insurance company has any deductibles, copayments, co-insurance, out-of-network or benefit limitations for medical, lab or diagnostic services. 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.

Deductible policy

If I have a deductible in the amount of $200.00 or more, I am responsible for paying a minimum $75 of my office visit at the time of service. Insurance will be billed after the services are rendered. If there is a remaining balance that my insurance will not cover, I will assume responsibility for paying the balance

Alternatively, if I have a deductible in the amount of $200.00 or more, I will allow Infinity Primary Care to save a valid credit card on file. Insurance will be billed for the services. When the visit is applied to my deductible, I authorize for my credit card to be charged the amount owed by me.

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.

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.

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 will 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" appointments can result in a service fee of up to $25.00 for an office visit or up to $50.00 for a physical exam or procedure. There will also be a $10 fee added if my copay is not paid at the time of service. I understand I am responsible for these fees and I understand they 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

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

INFINITY
PRIMARY CARE

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
PEDIATRIC HISTORY FORM
5 yrs. and older - PLEASE PRINT
(with Blue or Black Ink)

Today's Date:_____
Physician:_____

Name: (last) _____ (first) _____ Date of Birth: _____

Language spoken at home:_____

MEDICATIONS:
Please list all medications (including over-the-counter, vitamins, supplements, and/or inhalers)

NAME **STRENGTH** **FREQUENCY**

1._____

2. _____

3._____

4._____

5._____

ALLERGIES:
Is patient allergic to any drugs or medications?

☐ No ☐ Yes If yes, what?

Does the patient have any food allergies?

☐ No ☐ Yes If yes, what?

Does the patient have any other allergies?

☐ No ☐ Yes If yes, what?

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

Constitutional
O Chills
O Decreased activity
O Decreased appetite
O Fever
O Fussiness
O Weight gain
O Weight loss

HEENT
O Difficulty swallowing
O Ear drainage
O Esotrophia (cross eye)
O Eye discharge
O Eye redness
O Headache
O Hearing loss
O Nasal congestion
O Ear pain
O Sore throat
O Runny nose
O Sneezing
O Tearing
O Visual loss

Respiratory
O Breathing difficulty
O Use of accessory muscles
O Cough
O Sputum
O Wheezing

Cardiovascular
O Chest pain
O Palpitations
O Fainting

Vascular
O Cool extremity
O Blue coloration

Gastrointestinal
O Abdominal pain
O Constipation
O Diarrhea
O Nausea
O Reflux
O Vomiting

Genitourinary
O Decreased urine output
O Painful urination
O Urinary incontinence
O Flank (side) pain
O Foul urine odor
O Blood in urine

Reproduction (Female Only)
O Painful period
O Heavy flow
O Vaginal discharge
O Vaginal Itching
O Start Period age:____
Last Period_____
O Irregular menses
O Oral contraception

(Male Only)
O Circumcised
O Penile discharge
O Scrotum testicular mass
O Scrotum testicular pain

Metabolic/Endocrine
O Excessive thirst
O Excessive urination

Neurological
O Inappropriate interaction
O Behavioral changes
O Inconsolable
O Difficulty concentrating
O Distorted body image
O Self conscious

Skin
O Acne
O Itching
O Rash
O Skin lesion

Musculoskeletal
O Bone pain
O Joint pain
O Joint swelling
O Muscle weakness
O Muscle pain

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

Immunologic
O Seasonal allergies
O Environmental allergies
O Food allergies
O Urticaria (Hives)

Name: _____ **DOB:**_____

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

- O Acne
- O ADD
- O ADHD
- O Allergic rhinitis
- O Anemia
- O Asthma
- O Birth Trauma
- O Bleeding disorder
- O Bronchiolitis
- O Bronchitis
- O Chicken pox
- O Concussion
- O Congenital heart disease
- O Diabetes
- O Eczema
- O Fracture(s)
  Specify_____
- O GERD
- O Head Injury
- O Headache, migraine
- O Headaches
- O Hearing problems
- O Heart murmur
- O Meningitis History
- O Ear infections, recurrent
- O Pneumonia
- O Prematurity
- O Kidney infection
- O Seizure disorder
- O Seizures, febrile
- O Urinary tract infection
- O Vesicoureteral reflux
- O Other
  Specify_____
- O Genetic disease
- O Developmental issues

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

- O Adenoidectomy _____
- O Appendectomy _____
- O Blood transfusion _____
- O Dental surgery _____
- O Hernia Repair, inguinal _____
- O Hernia Repair, umbilical _____
- O Lymph node biopsy/excision _____
- O Tonsillectomy _____
- O Tympanostomy (Ear Tubes)
  Right Left Both
  Other_____

What diagnostic, screening studies or immunizations has the patient had previously? Please list most recent date.

Complete Physical _____ Last Cholesterol _____

Last Eye Exam _____ Last Hearing Test _____

Has child had all immunizations for his/her age?_____ If not, reason _____

Which ones are missing?_____ Can we give them today?_____

Name: _____ DOB:_____

FAMILY HISTORY: **Check below to report problems the patient's family members have had. Please state age when they had the problem if you know it and if this was a cause of death.**

☐ **Adopted (unknown family history)**

Condition	Whom	Onset Age	Cause of Death?
ADD/ADHD			
Alcoholism			
Allergies			
Asthma			
Birth defects			
Cancer (list type)			
Celiac Disease			
Heart disease			
Deafness			
Depression			
Developmental delay			
Developmental dislocation of hip			
Diabetes			
Eczema			
Elevated lipids			
Genetic disease			

Condition	Whom	Onset Age	Cause of Death?
Hemoglobinopathy (blood disorder)			
Hypertension			
Learning disability			
Mental retardation			
Migraines			
Obesity			
Kidney disease			
Scoliosis			
Seizure disorder			
Stroke			
Substance Abuse			
Sudden infant death syndrome (SIDS)			
Thyroid disease			
Mental Illness			
Other			

RELATIONSHIPS:

Child Care Provider: _____ Number of days/week_____

Who lives at the primary residence?_____ Who lives at the secondary residence?_____

Marital status of parents:_____

Siblings: How many?_____ Birth order:_____

Smokers at home? ☐ No ☐ Yes If yes, smoke outside only? ☐ No ☐ Yes

HOME ENVIRONMENT:

Is there lead in the home? ☐ No ☐ Yes ☐ Removed ☐ Unknown

Uses bike/skating helmet: ☐ No ☐ Yes

Car restraints: ☐ Car seat: face rear ☐ Booster ☐ None
☐ Car seat: face front ☐ Seat belt

Carbon Monoxide Detectors in home: ☐ No ☐ Yes

Smoke Detectors in home: ☐ No ☐ Yes

Radon in home: ☐ No ☐ Yes ☐ Untested ☐ Treated

Pets/animals at home: ☐ No ☐ Yes If yes, what kind?_____

Firearms at home: ☐ No ☐ Yes If yes, locked storage: ☐ No ☐ Yes
Ammo stored separately: ☐ No ☐ Yes

Name: _____ **DOB:**_____

EDUCATION:

Grade in school:_____

Grades earned: _____

Performing: ☐ Below grade level ☐At grade level ☐ Above grade level

Learning disability: ☐ No ☐ Yes

Special needs: ☐ No ☐ Yes

Gifted program: ☐ No ☐ Yes

SLEEP:

Sleeps with parents: ☐ No ☐ Yes

Sleeps through the night: ☐ No ☐ Yes

Nightmare/sleep problems: ☐ No ☐ Yes

ACTIVITY:

Exercise/sports/activity:_____ hours/day Type of exercise/sport?_____ Type of activity?_____

TV/computer games:_____ hours/day Has TV in bedroom? ☐ No ☐ Yes

Internet:_____ hours/day Has computer in bedroom? ☐ No ☐ Yes

NUTRITION: (over 5)

Type of Diet: _____

Concerns: ☐ No ☐ Yes _____

Caffeine: ☐ No ☐ Yes

Bladder concerns: ☐ No ☐ Yes

Bowel concerns: ☐ No ☐ Yes

Last Dental Visit: _____

DEVELOPMENTAL HISTORY:

Did your child achieve developmental milestones in an age appropriate matter?_____

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: _____

Please list the patient's mail order and/or primary pharmacy:

Pharmacy:_____

Address:_____

Phone No.:_____

Pharmacy:_____

Address:_____

Phone No.:_____

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

Physician: _____ **Visit Date: _____**

COMMUNITY LINKAGES SURVEY

We are dedicated to you, our patient and your family. If you are comfortable, please take a moment to answer the following questions so that we can help connect you with local community resources. Our staff is ready to answer any additional questions that you may have.

Please check ☑ Yes or No to the following questions:

1. In the past month, did **poor physical or mental health** keep you from doing your usual activities, like work, school or a hobby? ☐ Yes or ☐ No
2. In the past year, was there a time when you needed to see a doctor but could not because it **cost** too much? ☐ Yes or ☐ No
3. Do you ever eat less than you feel you should because there is not enough **food**? ☐ Yes or ☐ No
4. Do you need a job or other **steady source of income**? ☐ Yes or ☐ No
5. Are you worried that in the next few months, you may not have adequate **housing** that you own, rent or share? ☐ Yes or ☐ No
6. In the past year, have you had a hard time paying your utility company **bills**? ☐ Yes or ☐ No
7. Does getting **child care** make it hard for you to work, go to school or study? ☐ Yes or ☐ No
8. Do you think completing more **education or training**, like earning a high school diploma, going to college, or learning a trade, would be helpful for you? ☐ Yes or ☐ No
9. Do you need a dependable **way to get to work or school** and your appointments? ☐ Yes or ☐ No
10. Do you need **household supplies**? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo. ☐ Yes or ☐ No
11. If you take **medication**, are you not taking it because it is too expensive? ☐ Yes or ☐ No
12. Do you need help **finding or paying for care for loved ones**? For example, child care or day care for an older adult. ☐ Yes or ☐ No
13. Do you **feel unsafe** in your home or living situation? ☐ Yes or ☐ No
    - If you answered ☑ Yes, would you like to receive assistance with any of these needs? ☐ Yes or ☐ No
    - Are any of your needs **<u>urgent</u>**, please write the Number of the Need (1-11)? **_____**

My name: _____ **Date of Birth**: _____

Survey completed by (if other than the patient): _____

My best telephone number: _____

(version 10.2018)