ENVISION MEDICAL GROUP – PATIENT REGISTRATION FORM

Today's Date:	PCP:	PCP PHONE:

PATIENT INFORMATION

Suffix:	Last Name:	First:	Middle:
Birth Date:	Age:	Sex:	SSN#:
Marital Status:	Ethnicity:	Preferred Language:	Race:

Address:	Primary Ph:	Secondary ph :
Email (For secure access to your records):	**Preferred Contact:**	
Primary Pharmacy:	Phone:	City:
Cross streets:		
Secondary Pharmacy:	Phone:	City:
Cross streets:		

GUARANTOR INFORMATION

Name:	**Gender:**	**DOB:**
Address:	**Phone:**	**Relationship:**
Policy Holder Name:	**Policy Holder DOB:**	

IN CASE OF EMERGENCY

Name of local friend or relative (primary):	Relationship to patient:	Home ph:	Work ph:
Name of local friend or relative (primary):	Relationship to patient:	Home ph:	Work ph:

The above information is true to the best of my knowledge. I authorize the release of any medical information, including information to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I authorize payment directly to Envision Medical Group, PLLC for services rendered. I understand that I am responsible for services performed without a valid HMO authorization form from my primary care physician, if my insurance does not guarantee coverage and/or payment. I further understand that I am responsible for payment of services rendered whether denied by my insurance company or in the case I have no insurance coverage.

Patient/Guardian signature *Date*

ELECTRONIC MEDICATION TRANSMISSION AUTHORIZATION

Your signature below authorizes EMG to download your medication history from the national SureScripts database and submit medication requests to the pharmacy using SureScripts clearinghouse.

Patient/Guardian signature *Date*

Privacy Notice: Envision Medical Group, PLLC ("EMG") is required by law to maintain confidentiality of patient health information (PHI). EMG works hard to ensure PHI is kept confidential and will NOT share PHI with individuals/entities not involved in services provided by EMG. (For a copy of EMG's Privacy Practices please check with your provider or contact our corporate offices at (248) 471-0675.) EMG will NOT distributed your email address for any reason.

Patient Request to Release Protected Health Information

Dear Patient, you have requested all or part of your protected health information be provided to another provider or entity indicated below. Michigan law required we have your signed authorization to release this information. You must complete this form prior to our release of the needed information.

Patient Name_____ Date of Birth:_____

SSN:_____ Doctor's Name:_____

Practice Name: ENVISION MEDICAL GROUP, PLLC

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:
Name:_____(FAMILY/FRIEND)_____
DOB:_____City, State: _____ Zip Code: _____

Phone: ( )_____Fax: ( )_____

This request and authorization applies to health care information relating to the following treatment and condition for:

Dates of Treatment: _____

☐ All health care information available at this practice.

☐ Other:

The above information may be released by: Mail ☐ Fax ☐ Phone ☐ Other ☐

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave my permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- *Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Healthcare Information" or*

Write a letter to the doctor or practice. If I write a letter, it must state that I want to cancel my authorization to disclose my healthcare information. My letter must include the name or the specific identification of the person(s) that I no longer want to receive information. I (or authorized representative/care giver) must sign and date the letter.

Once my doctor gives out the information that I want to release, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.

_____ _____
Signature of patient/patients authorized representative Date signed

_____ _____ _____
Parent, legal guardian, caregiver Relationship Date signed

Authorization for Release of Medical Records

I,_____, authorize Envision Medical Group, PLLC and its physicians, agents and employees to provide for photocopy or to allow for my medical records to be inspected or reviewed for the express purpose of:

1.) Management and coordination of clinical services and care.
2.) Benefit and payment determinations.
3.) Quality assurance and or quality improvement activities.
4.) Personal use.

I authorize the release of the medical record information specified below to Envision Medical Group, PLLC for the purpose indicated above. The following medical information is the subject of this authorization:

- ☐ The entire medical record and history of care.
- ☐ Portions of the medical record for the period_____to_____
- ☐ Specific diagnosis:_____
- ☐ Office and progress notes for the period_____to _____
- ☐ Hospital admissions and discharge summaries.
- ☐ Hospital notes.
- ☐ Operative reports, notes, findings, etc.

I understand and agree that my patient records released may include:

- Alcohol and/or drug abuse information protected under the regulation in 42 code of Federal Regulations, Part 2.
- Psychological and/or social service information.
- Information about HIV, AIDS, or ARC protected under MCL 333.5131 or any communicable disease.

This authorization is valid for a maximum of 2 years from the date of the signature below or until expressly revoked by the undersigned.

_____ _____

Signature of Patient/Patients Legal Representative Date

_____ _____

Patient Caregiver Patient Date of Birth

ENVISION MEDICAL GROUP, PLLC **NOTICE OF PRIVACY PRACTICES**

All employees, staff, and those involved with your treatment, payment or the operations of our offices will follow this notice. We are required by law to:

- **Make sure that medical information that identifies you is kept private.**
- **Give you this notice of our legal duties and privacy practices with respect to your information, and follow the terms of the notice that is currently in effect**.

How we will use and disclose medical information about you:

1. **Treatment.** We will use medical information about you to provide you with treatment or services. We will disclose covered information about you to others who also are involved in your treatment or taking care of you. For example, other healthcare provider, labs, physical therapy, Medicare or Medicaid, or your family or friends who are involved in your care decisions. We will also provide your referring physician or subsequent health care provider with copies of various reports to assist him or her in treating you.
2. **Payment.** We will use and disclose covered information about you so that the treatment and services you receive can be billed to and payment may be collected from you, your insurance company or a third party.
3. **Health care operations.** The law permits us to use and disclose covered information about you for the operation of our practice. These uses and disclosures are necessary to run the practice and make sure all patients receive quality care.
4. **Notification.** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, or your location and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided us; e.g., on an answering machine.
5. **Business associates.** There are some functions or activities that are provided for our organization through "contracts" with third party "business associates." Examples include consultants and attorneys. When these services are contracted we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information we require the business associates to agree in writing to appropriately safeguard your information.
6. **Communication with individuals involved in your care.** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health care information relevant to that person's involvement in your care, or payment related to your care. We may also disclose private health information of deceased patients to a family member, friend, or representative (even absent probate) if that individual had been involved in the deceased patient's care or payment before death, unless disclosure would be inconsistent with the patient's wishes expressed to us in writing.
7. **Research.** Under certain circumstances, we may use and disclose medical information about you for research projects. We will ask for your specific authorization if the research information includes items of your identity.
8. **Where required by law.** We will disclose information about you where required by local, state, or federal law. For example, federal law may require your health information to be released to an appropriate health oversight agency, public health authority, or attorney.
9. **Coroners, medical examiners, funeral directors.** We will release medical information about you if necessary, for example, to identify a deceased person or determine the cause of death.
10. **Public health.** We will disclose medical information about you for public health activities. These activities generally include the following:
    - To prevent or control disease, injury or disability.
    - To report child or adult abuse, neglect or exploitation.
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
    - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required or authorized by law.
    - To report births and deaths
    - To report reactions to medications or problems with a product.
11. **Worker's compensation.** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs which may apply to your condition.
12. **Lawsuits and disputes.** We will disclose health information about you in response to a court or administrative order, subpoena, discovery request, or other lawful purposes.
13. **Health oversight activities.** We will disclose medical information about you to a health oversight agency for activities authorized by law. For example, audits, investigations, inspections, peer review, credentialing, and licensure.
14. **Military and veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel when necessary.
15. **Organ and tissue donations**. If you are an organ donor, we may release your medical information to an organization that handles organ procurement or organ eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
16. **Other uses of medical information.** Certain ways that your protected health information could be used or disclosed require an authorization from you: use or disclosure for marketing and disclosures or uses that constitute a sale of protected health information. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. Other uses and disclosures not described in this notice will be made only with your written authorization, which you may revoke going forward in writing.

Your Rights Regarding Medical Information about You

1. **Access to and copies.** You have the right to access your records and /or to receive a copy of your records. Your request must be in writing. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you, or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
2. **Right to amend.** Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
3. **Right to an accounting of disclosures.** This is a list of the disclosures we made of your medical information that was not related to treatment, payment, or operation of the office as we have listed. To request this accounting of disclosures, you must submit your request in writing. You are entitled to one accounting without change. You may be charged for subsequent lists. You will be told the cost involved, and may withdraw or modify your request. In the event of unauthorized disclosures we are obligated to notify you of this event and what information, if any, was disclosed without authorization.
4. **Right to request restrictions**. You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment. We are also required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item or for health operations, if you have paid for the item or service in full "out-of-pocket", and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose the information that has been restricted to business associates that may disclose the information to the health plan.
5. **Right to request confidential communications.** You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing and may be revoked in writing and must give us an effective means of communications for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
6. **Right to paper copy of this notice.** You have the right to a paper or electronic copy of this notice. You may ask us to give you a copy of this notice at any time.
7. **Changes to this notice.** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the notice that is in effect in the office and have a copy of the current notice available for you upon request.
8. **Complaints.** You have the right to file a complaint without being penalized. If you believe your privacy rights have been violated, you may file a complaint in writing to the office manager. You also have a right to file a complaint regarding privacy violation to the Office for Civil Rights. You will not be penalized for filing a complaint.

Privacy Officer Phone Number: 248-471-0675 Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We will be asking you to sign an acknowledgement of our office providing you with this Privacy notice as required by HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security rules. Your signature does not obligate you in any way. It simply verifies that we notified you of privacy standards and your rights.

Revised: February 8, 2015

Acknowledgement of Receipt of Practices Privacy Notice

I acknowledge that I have received and/or reviewed the notice of the Privacy Practices of this office. I am aware that this notice of the Privacy Practices is posted in the office and online where I can review it if I desire.

Patient, Patient Representative, Parent or Legal Guardian Date

Patient Caregiver

Documentation of "Good Faith Effort"

Patient Name:_____

The patient presented for the treatment on this date and was provided Envision Medical Group's Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

Patient refused to sign, with the reason:_____

Patient is unable to sign due to: _____

There was a medical emergency preventing a timely signature, and an attempt will be made to obtain acknowledgement later.

Other:_____

Signature of EMG Representative Date