REGISTRATION MICHIGAN COMPASSIONATE CARE & EASTERN CARE

(PLEASE PRINT)

Date ..... Home Phone .....

Patient ..... (Last Name, First Name, Initial)

Responsible Party (if a minor) .....

Street Address .....

City ..... State ..... Zip .....

Sex ☐ M ☐ F Age .....Birthdate ..... ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By .....

Business Address .....

Occupation ..... Business Phone .....

Spouse (or responsible party) Name ..... Birthdate .....

Business Name and Address .....

Occupation ..... Business Phone .....

Who is responsible for this account? ..... Relationship to Patient .....

Social Security # ..... Spouse's Social Security # .....

Do you have Medical Insurance? ☐ No ☐ Yes

In case of emergency, **who should** be notified? ..... Phone .....

How did you learn of our practice? .....

Insurance Name; _____ -- _____

I hereby consent to evaluation, testing and treatment as directed by my physician or his or her designee.

I hereby authorize direct payment under Medicare/Medicaid/CHAMPUS or other other insurance providers to Michigan Compassionate Care, Eastern Care or the physician individually for services rendered to me or my dependent by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services, I am to receive, are a covered benefit. I understand and agree that I will be responsible for any co–pay or balance due to Michigan compassionate care, Eastern care or the physician individually.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the medicare carrier.

I certify that the information given by me in applying for payment under Medicare/Medicaid/CHAMPUS or other insurance providers is correct. I authorized a release of any of my or my dependents record that these programs may request or otherwise necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

I certify that I have received and reviewed a copy of Michigan compassionate care and Eastern care patient information privacy policy.

I hereby authorize Michigan compassionate care, Eastern care, individual physician or their representative to mail, call or email me with communication regarding my health care, including but not limited to such things as appointment reminders, referral arrangements, test results. I understand that I have the right to rescind this authorization at any time by notifying Michigan compassionate care, Eastern care or individual physician to that effect in writing.

I understand my medical care may includes labs, x-rays or other diagnostic services. I may receive a seprate bill for those services. I further understand that I am financially responsible for any co–pay or balance due for the services if they are not reimbursed by my insurance for whatever reason.

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Beneficiary/ Insured/ Guardian Signature Date