John N Campbell MD PC
Internal Medicine / Addiction Medicine

1676 Viewpond Dr SE
Suite 100A
Kentwood MI 49508

P: 616.455.9450
F: 616.455.5221
www.JohnCampbellMD.FromYourDoctor.com

PATIENT REGISTRATION

First Name: _____ Middle Int:_____ Last Name:_____

Date of Birth:____/_____/_____ Age:_____ SSN: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone:_____ Cell:_____ Work: _____

E-mail: _____

CHECK ONE
This office **MAY_____/MAY NOT_____** leave voicemail message(s) regarding: appointment reminders, lab or X-ray results or billing questions on the phone numbers/Email(s) listed on this form.

Gender: Male/Female (Circle One)

Marital Status: Single/Married/Separated/Divorced/Widowed (Circle One)

Spouse's Name:_____

Your Occupation: _____Employer: _____

Referred to John N Campbell MD PC by: _____

Are all of your childhood immunizations up to date? Yes/No Last Tetanus shot:_____

Do you receive a yearly flu shot? Yes/No

Are you allergic to any medications? _____

In case of emergency notify: _____ Phone: _____

Patient Signature: _____ **Date:** ___/____/_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I,_____, authorize the following person(s) to access my entire health
(Your Name)
record. I understand that this authorization is voluntary and I may revoke this authorization at any time. I understand my right not to sign this document preventing anyone from accessing my medical record. This authorization shall remain in effect until I have submitted my written revocation.

Authorized person(s):

Name:_____Relationship:_____

Phone Number:_____

Name:_____Relationship:_____

Phone Number:_____

Name:_____Relationship:_____

Phone Number:_____

CHECK ONE
This office **MAY_____/MAY NOT_____** leave voicemail message(s) regarding: appointment reminders, lab or X-ray results or billing questions on the phone numbers listed on this form.

Patient Name(print):_____**DOB**_____**Date:**_____

Signature:_____**Relationship to patient:**_____

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Financial Agreement and Policies

Dr. Campbell accepts all insurance plans. However, there are some plans that do not reimburse for services if Dr. Campbell is considered by the insurance company to be "out of network". We strongly advise all new patients to check with their insurance company first.
In addition, there are services that are not billed to the insurance company and are paid for by the patient. Our practice is required to inform you of these non insurance paid services and obtain your signature that you understand and accept financial responsibility (i.e., "waiving your insurance rights").

For patients receiving controlled substances

- You will be subject to toxicology screenings as part of your medical treatment, random toxicology services are required by the DEA when prescribing controlled substances. These screenings will be given randomly at any appointment throughout the course of treatment. However, some insurance plans do not pay for this service. Dr. Campbell is permitted to offer a discount when paid at the time of service. The front desk (where you check in) is usually not aware when patients have the toxicology screening, it will be the patient's responsibility to either pay before leaving the office or within the week.

  I am waiving my insurance rights, and accept responsibility to pay for this service discounted to $15 when paid at the time of service or within the week or $41 if not paid within the week from time of service, same charge for all insurance companies.

  _____ (Signature)

EVERYONE

- Changing appointments less than 24 hours and No Shows: There is a $25 charge whenever an appointment is changed less than 24 hours and for missed appointments. This amount must be paid before seeing the provider again. Please initial here which indicates that you understand and agree to this policy _____ (Initials)

- Copays/Deductibles: Copays must be paid at the time services are rendered. If you have a deductible, please be expected to pay your balance at your next visit. If the payment cannot be made, patients will receive a prescription for a few days. Once a payment is made the provider will authorize and call the pharmacy to release another few days or a week. This process will continue until the balance is paid. Please initial here which indicates that you understand and agree to this policy _____(Initials)

I, (Print Name)_____, read and initial each point above indicating I understand and will actively participate in my recovery process.

_____Date:_____

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General Consent for Treatment and Release of Information

Treatment

I agree to all treatment ordered by providers in this office and acknowledge that I have a right to refuse treatment at any time. I agree to allow students and healthcare staff to review my records for treatment and teaching purposes. Michigan law allows my blood to be tested without my consent for HIV or Hepatitis if an exposure occurs pertaining to a healthcare professional.

Charges for Treatment

I am responsible for all charges not covered by my insurance. Co-pays, Deductibles, Co-insurance.

As a part of medical treatment at John N. Campbell MD PC, random toxicology services are required when prescribing controlled substances. Most insurance companies do not cover this service.

Release of My Medical Information

I understand that my medical records may be shared with health professionals involved in the treatment of my care, insurance companies, government agencies for Medicare or Medicaid. I understand I have the right to cancel in writing any permissions to release my medical information unless the documents were already transmitted.

Medical Records

Records can be released with a signed Medical Records Release Form. Please allow 7-10 days for the processing of these requests. There may be an administration fee assessed for printing and processing a request based on how many pages your request entails.

Missed Appointments

We ask that you keep all scheduled appointments. However, if this is not possible, we require a 24 hour notice to cancel. Failure to give this notice will result in a charge of $25. This fee is not covered by insurance and is your responsibility. Three No-Show appointments can result in being discharged from the practice.

Returned Checks (NSF)

There is a $50 fee for any check or returned payment and this form of payment will no longer be accepted.

Prescription Refills

You must allow 48 hours to process any prescription refills. Please call ahead to refill your prescriptions so you do not run completely out of medication.

Forms

A form fee may be charged for the completion of forms such as FMLA, disability, etc. The fee will be based on the time involved and length of the form.

I understand that I am responsible for all services whether or not paid by insurance. I authorize John N. Campbell M.D., P.C. to release any medical records or information necessary to my insurance to secure payment of benefits. I acknowledge that I have read and understand all office policies above and have acknowledged that I have received the notice of privacy practices.

Patient name (print):_____ **Relationship to Patient:**_____

Signature:_____ **Date:**_____

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications are very useful for appropriate indications but also have a high potential for misuse. Federal, state and local government agencies have mandated healthcare providers follow strict guidelines when using these medications when treating patients. Because I am prescribed such medications I agree to the following:

I am responsible for all of my medications. If the prescription is lost, misplaced, stolen or if I consume the medication in any way other than exactly how it is prescribed I understand it may not be replaced. _____

I will not request or obtain any controlled medications from any other physician while bound by this contract unless they are prescribed during an inpatient hospital stay or with written permission from my provider._____

I agree to release all records (past and present) if requested to John N. Campbell M.D., P.C. _____

I am responsible for requesting refills in a timely manner during office hours Monday through Thursday to prevent running out of my medications. Refills will not be made after office hours, on holidays, Fridays and weekends._____

If requested, I will bring in my prescriptions in the original pharmacy dispensed bottles each time I am seen in the office regardless of the quantity of pills that remain._____

I understand if any conditions of this contract are violated I can be immediately discharged from the practice._____

I understand that random drug testing will be done. If the results are not satisfactory, my provider may discharge me immediately._____

List all controlled substance(s) you are taking:

Medication:_____

Medication:_____

Medication:_____

Medication:_____

I have read this contract and it has been explained to me by my provider and/or their staff. In addition I fully understand the consequence for violating any of the above stated terms.

Patient_____**DOB:**_____**Date:**_____
(Signature)