# Welcome to Dr. Kennedy's Practice!

## Patient Information:

Name **:** _____ Birth date **:** __/__/__ Age **:** _____ O Male O Female

(As Printed on ID) Last First MI

Address **:** _____

Street Apt# City State Zip Code

Marital Status **:** Single Married Widowed Divorced Last FOUR of SS#__ __ __ __

Home Phone **:** (___) _____ Cell Phone **:** (___) _____

Work Phone **:** (___) _____ Email **:** _____

Emergency Contact **:** _____

Relationship to patient **:** _____ Phone # **:** (___) _____

**I authorize the release of medical records in order to process and medical claims.**

**I understand that I am responsible for any professional services not paid for by my Insurance carrier. I certify that the above information is accurate to the best of my knowledge.**

Patient Signature **:** _____ Date **:** _____

Guardian Signature **:** _____ Date **:** _____

**Patient Personal History :** Height **:** _____ Weight **:** _____

**Ethnicity & Race are a federal requirement mandated by CMS- Centers for Medicare and Medicaid Services **:**

O Hispanic or Latino O African American O Native American O White O Other

O American Indian, Alaska Native O Asian O Native Hawaiian, Pacific Islander O Decline

**Gender Identity: O Male O Female O Female to Male O Male to Female O Other O Do Not Disclose

**Sex Orientation O Lesbian, Gay, or Homosexual O Heterosexual O Bisexual O Other O Do Not Disclose

Preferred Language **:** O English O German O Spanish O French

**Social History :** O Work in Home O Occupation **:** _____ O Student School **:**

Do you have any children? O Yes O No How many? _____ Do you feel safe at home: OYes ONo

Tobacco O Yes O No How many per week? _____

Alcohol O Yes O No How much per day? _____ How much per week? _____

**Pharmacy Name :** _____ Address: _____ Phone: _____

**Patient Medical History :**

Please check all illnesses or disease you have had in the past or currently have.

O High Blood Pressure O Kidney Problems O Bladder Issues O Asthma

O Disease of Colon O Heart Disease O Hiatal Hernia O Anxiety

O Psychiatric Illness O Congestive heart fail O Stomach Ulcers O Gout

O Blood Clot Disorder O Angina/ Chest pain O Hemorrhoids O Stroke

O High Cholesterol O Thyroid Disease O Depression O Anemia

O Chronic Bronchitis O Diabetes O Head Injuries O Allergies

O Seizures/ Epilepsy O Other Heart Disease O Osteoporosis O Arthritis

O Other Lung Disease O Ear Problems O Eye Problems O Pneumonia

O Broken Bone O Liver Disease O Emphysema O Cancer (specify) _____.

O Other (specify) _____.

Please list all surgeries and or operations you have had along with the date performed below **:**

**1 :**_____ Date **:**_____

**2 :**_____ Date **:**_____

**3 :**_____ Date **:**_____

**4 :**_____ Date **:**_____

Please list all medications/ dosages you are currently taking (if known) **:**

**1 :**_____Date **:**_____

**2 :**_____ Date **:**_____

**3 :**_____Date **:**_____

**4 :**_____Date **:**_____

Allergies **:**

**1 :**_____Date **:**_____

**2 :**_____Date **:**_____

**Specialist information :**

1. Doctors Name **:** _____ Specialty **:**_____

Address **:** _____ Phone **:**_____ Fax **:**_____

2. Doctors Name **:** _____ Specialty **:**_____

Address **:** _____ Phone **:**_____ Fax **:**_____

3. Doctors Name **:** _____ Specialty **:**_____

Address **:** _____ Phone **:**_____ Fax **:**_____

# HIPAA Agreement for Dr. Colleen Kennedy

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession.

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct health care operations.

*A copy of the HIPAA law is available at our front desk if interested.*

Patients Name:_____ Date:_____

Patients DOB:_____

Guardian Name if child is a minor (under 18):_____

Below are ways we will contact you with test results or information. Please list the options our office staff is able to utilize.

Email Address:_____

Emergency Contact Name/Relationship_____Phone: _____

Home phone :(____)_____ Cell Phone:(____)_____

Name of those to whom medical information may be disclosed:

(1)_____ Relationship to patient:_____

(2)_____ Relationship to patient:_____

(3)_____ Relationship to patient:_____

****Please read the below thoroughly before initialing and checking*****

I understand that in order for Dr. Kennedy and office to provide the best medical care possible I must follow the instructions included in this packet and to notify the office if I experience any problems with my treatment. **Initials:_____**

I do_____ or I do NOT_____ give my permission for the doctor/ staff to give any test results/ Information (blood, biopsy, culture, etc.) to a family member of which I have listed above if I cannot be reached. **Initials:_____**

I do_____ or I do NOT_____ give my permission for the doctor/ staff to leave test results on the voicemail boxes of the phone numbers I have given above. **Initials:_____**

I have been offered a copy of the four pages of HIPAA for the office of Dr. Colleen Kennedy D.O.

**Initials:_____**

For office use only:

Initials of employee responsible for entering/documenting packet in full:_____ Date completed:___/___/_____

Statement of Financial Policy

Thank you for choosing us as your primary care physician! We are committed to the success of our treatment and care. Please understand that payment of your medical bills is part of this treatment and care. The following is a statement of financial policy, which we require all of our patients to read, understand and sign prior to any non-emergent treatment of care.

In order for our office to successfully bill your insurance company, we need complete information and require a copy of your insurance card and state ID at every visit. Please cooperate with our reception staff in providing accurate information.

Information regarding insurance coverage:

*Co-Pay: Copayments are a set dollar amount that you are required to pay according to your insurance policy at each office visit. Every patient will be responsible for paying their office co-pay at the front desk on the date services are rendered.

*Deductibles: This is a set dollar amount that is required annually to be paid by the insured. The insurance will not pay any of the claims until this amount is paid by the patient. We are required to collect this amount in full. We are not allowed to adjust off any portion of this payment.

*Commercial/Indemnity Insurance: Your policy is a contract between you and your insurance company. Since we are not a party to that contract, your account balance and whether your insurance pays or not is your responsibility. As a courtesy we will file a claim on your behalf.

*Managed Care Plan (PPO,POS,HMO): You are responsible for paying any co-payments, deductibles, and noncovered services. It is your responsibility to verify a physician's participation in your health plan prior to making an appointment. Please understand that if you fail to do so your insurance carrier may not authorize the visit. We must comply with your insurance company's rules and most insurance companies will NOT issue a retroactive referral for services.

*Self-Pay: Patients who do not have insurance coverage or who are unable to provide us with valid insurance information are responsible to pay 100% of the charges at the time services are rendered.

***Your insurance policy determines the amount you are responsible to pay. Medical Providers are not allowed to adjust off any co-payments or deductibles***

Please keep in mind, our staff has been trained to understand many insurance policies, but they DO NOT have all the answers about your specific plan or benefits. Please contact your insurance company to obtain detailed information about your coverage.

All outstanding balances are due and will be collected at your next date of service if no payment is received regardless of receiving a statement.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY AND I UNDERSTAND AND AGREE

SIGNATURE: _____

PRINT NAME: _____

COLLEEN KENNEDY DO PC
427 West University Drive
Rochester, Michigan 48307

**A PATIENT-CENTER MEDICAL HOME IS A PARTNERSHIP BETWEEN THE PATIENT AND COLLEEN KENNEDY PO DC**

**Being a part of a Patient-Centered Medical Home, Dr. Colleen Kennedy's office will:**

- Work with you on improve your health
- Review your medication at every visit and recommend changes if needed
- Develop a plan with you to improve your health and manage any chronic health problems
- Set health goals with you and monitor your progress to help you stay healthy
- Use computer technology as needed to optimize your care
- Provide you with educational material and information about community programs that will help you improve your health
- Provide 24 hour phone access to all medically trained professional
- Work with after-hours care centers to be informed of your visit within 24 hours
- Offer same day appointments when needed

**By choosing to participate in a Patient-Centered Medical Home, I agree to:**

- Make sure my doctor knows my entire medical history
- Tell my doctor all the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Follow my doctor's recommendations
- Frequently sign into my patient medical record portal to update my medical history, review messages, and communicate with my provider(s) when necessary
- Ask my doctor questions about things I don't understand
- Ask my Primary Care Physician for advice before making an appointment with a specialist
- Ask other health care providers to send my doctor information such as lab or test results, x-rays, or treatment notes
- Understand my insurance, what it covers and update the office with changes - Provide the office feedback on how they can improve my care

I have read and understood the meaning of the partnership between myself and Colleen Kennedy's DO PC office as being part of the Patient-Centered Medical Home

_____
PLEASE PRINT YOUR NAME LEGIBLY

_____ _____
SIGNATURE DATE