HILL ORTHOPEDICS
11446 E. 13 Mile Rd., Ste. C
Warren, MI 48093

PATIENT INFORMATION

NAME: _____
Last First Middle Initial

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

SEX: Male Female MAIDEN NAME/OTHER NAMES USED/PREFERRED NAME: _____

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ /_____ Okay to leave message: Y N
Home Cell

EMAIL: _____ (Only used for patient portal registration)

MARITAL STATUS: Single ___ Married ___ Divorced ___ Widowed ___ STUDENT STATUS: Full-Time ____ Part-Time ____

PRIMARY CARE PHYSICIAN INFORMATION

PRIMARY CARE PHYSICAN'S NAME:

_____
Last First Phone

ADDRESS:

_____
Street City State Zip

Did this physician refer you to see Dr. Hill (circle one) YES NO If no, who referred you? _____

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY
If "self" please circle and skip to insurance information

(CIRCLE ONE) Self Partner/Spouse Child Step-Child Foster-Child Grandchild Legally appointed person

FINANCIALLY RESPONSIBLE PARTY INFORMATION –
(Self if over 18, present parent if minor patient, or other if trust or legal guardian)

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ /_____ Okay to leave message: Y N
Home Cell

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

INSURANCE INFORMATION (Complete both if Primary/Secondary are part of Patient Coverage)

PRIMARY	SECONDARY
INSURANCE: _____	INSURANCE: _____
SUBSCRIBER: _____	SUBSCRIBER: _____
SUBSCRIBER SSN: _____	SUBSCRIBER SSN: _____
SUBSCRIBER D.O.B.: _____	SUBSCRIBER D.O.B.: _____

I AUTHORIZE, WITH MY SIGNATURE AT THE END OF THIS DOCUMENT, THE RELEASE OF MEDICAL INFORMATION TO THE BILLING AGENT OF HILL ORTHOPEDICS, MY INSURANCE CARRIER(S) AND/OR THEIR AGENT(S) FOR PAYMENT OR DIRECT REIMBURSEMENT LESS ANY DEDUCTABLE OR CO-PAY I MAY OWE.

NURSING/REHABILATION CENTER INFORMATION

NAME OF FACILITY: _____

DATE OF ADMISSION: _____

ADDRESS: _____
Street City State Zip

PHONE: _____

Patient should notify office when they are discharged from facility or if there is a facility change

SURROGATE DECISION MAKER
Person who makes your medical decisions for you

DO YOU HAVE SOMEBODY ELSE THAT MAKES MEDICAL DECISIONS ON YOUR BEHALF: Yes No

NAME: _____
Last First Phone Relationship to patient

IS THIS PERSONALLY LEGALLY ASSIGNED TO MAKE DECISIONS ON YOUR BEHALF: Yes No

ASSIGNMENT OF BENEFITS – MEDICAL INFORMATION, PHOTOGRAPHY AND PROCEDURE RELEASE

Patient Name | Policy Holder Name

Patient Date of Birth | Subscriber's Relation to Patient

I hereby authorize payment directly Hill Orthopedics for all medical and surgical, basic, and/or medical otherwise payable to me for all treatment of the above-named patient. I understand that I am financially responsible for charges to said corporation for charges not covered by my policy. I further authorize the physician to release information requested by my insurance company in order to verify and process said claim(s).

Also, by my signature I authorize Hill Orthopedics to release to the Employer, Compensation/Insurance Carrier, and/or Referring Physician any and all records or reports pertaining to the medical treatment. This will also authorize release of necessary reports to any physician to whom the patient is referred.

I am also aware that Hill Orthopedics may obtain photographs of my body for medical/legal purposes. My signature authorizes use of these photographs in this manner.

I understand that for a successful Physician/Patient relationship it is important for me, as a patient, to return for scheduled appointments and comply with the Physician's medical instructions and otherwise cooperate with my Physician. The Physicians of Hill Orthopedics reserve the right to discontinue, permanently or temporarily, the Physician/Patient relationship in the event the relationship is impaired as a result of my action or inaction.

I consent to any medical, diagnostic, therapeutic, or minor surgical procedures rendered to myself under the supervision of the physicians of Hill Orthopedics.

Hill Orthopedics is a privately owned, full-service health care delivery system which includes St. John Oakland-Macomb and Henry Ford Macomb Hospitals, acute care Hospital facilities, outpatient surgical center, several physical therapy locations and diagnostic imaging services, including MRI, CT Scan, and Ultrasound. Please understand if you receive care within this system, you are choosing a facility where your treating physician may have a financial interest.

I understand there will be a charge of $35.00 for any returned checks. I also understand that Hill Orthopedics reserves the right to use an outside collection agency as a means of collecting an outstanding balance if my account remains unpaid or payment arrangements are not made. I understand that if my account goes to collections, I will be assessed an additional $25 or 35% collections fee, whichever is more. I understand it is my responsibility to keep scheduled appointments or notify the Hill Orthopedic staff 24 hours prior to scheduled appointment or be charged a $50.00 no show fee. This fee is due at the next appointment and cannot be billed to your insurance carrier. In the case of emergencies, your physician may grant an exception with proper documentation.

Legal documentation must be show if someone other than patient is signing on behalf of patient.

Patient/Parent/Guardian Signature **Date**

HIPAA PRIVACY ACKNOWLEDGEMENT
Person/persons whom we can communicate any information in your medical record to

Patient Name: _____

Please tell us which family members or (emergency contact) we may speak with concerning your medical information:
Check the box next to name if the person is also your emergency contact.

☐ _____

Name Relationship Phone

☐ _____

Name Relationship Phone

If the names listed above are not also your emergency contact, please give an emergency contact's name below.

_____

Name Relationship Phone

Acknowledgement:
I acknowledge that I have received the Notice of Privacy Practices from Hill Orthopedics.

Legal documentation must be show if someone other than patient is signing on behalf of patient.

_____

Patient/Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____