McLAREN MACOMB
ADULT REGISTRATION

Language Preference: ☐ English
☐ Other specify: _____

PATIENT INFORMATION

PATIENT NAME (Last) (First) (Middle)				❑ Male ❑ Female
ADDRESS	CITY	STATE	ZIP CODE	BIRTH DATE | | — | | — | | | |
TELEPHONE ( )	SS# | | | — | | — | | | |	STATUS: ❑ Single ❑ Married ❑ Divorced ❑Widowed ❑ Legally Separated ❑ Domestic Partnership/Civil Union		RACE: ❑ Asian ❑ Multi-Racial ❑ African American/Black ❑ Caucasian/White ❑ Other ❑ Decline to Answer
CELL PHONE	E-MAIL ADDRESS	ETHNICITY: ❑ Hispanic/Latino ❑ Non-Hispanic /Latino ❑ Decline to Answer ❑ Unknown		
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE ( )	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	
PRIMARY CARE PHYSICIAN	REFERRED OR RECOMMENDED BY			

SPOUSE /LEGAL GUARDIAN INFORMATION

NAME (Last) (First) (Middle)			RELATIONSHIP
TELEPHONE ( )	SS# | | | — | | — | | | |		BIRTH DATE | | — | | — | | | |
ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE ( )
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE		SUBSCRIBER	BIRTH DATE
ADDRESS		CITY STATE	ZIP CODE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME
INSURANCE COMPANY TELEPHONE ( )		PRE-CERTIFICATION TELEPHONE ( )	

SECONDARY INSURANCE		SUBSCRIBER	BIRTH DATE
ADDRESS		CITY STATE	ZIP CODE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME
INSURANCE COMPANY TELEPHONE ( )		PRE-CERTIFICATION TELEPHONE ( )	

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME		RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP CODE
WORK TELEPHONE ( )	HOME TELEPHONE ( )		
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE ( )	

UPDATES

PATIENT/LEGAL GUARDIAN SIGNATURE	**DATE**

DATE	SIGNATURE	DATE	SIGNATURE

CONSENT TO ADMISSION I TREATMENT

This is to certify that I (we) the undersiqned, hereby consent to all medical care deemed necessary on the judgment of the named attending physician(s) or other medical staff members of the Clinic and/or McLaren Medical Center Macomb including but not limited to diagnostic procedures, x-ray, administration of medication.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me with respect to any diagnostic procedures or as to the results of the care and treatment which I have hereby authorized.

If I should leave the Clinic and/or the Hospital against the judgment or advice of any attending physician(s), I hereby relieve said physician(s) and the Clinic and/or the Hospital of all responsibility for my action.

I understand that an HIV (human-immuno deficiency virus - AIDS) test may be performed on me without my consent should a health care provider be exposed to my blood or body fluids or open wound.

CONSENT TO RELEASE MEDICAL RECORDS

I understand that the Clinic and/or the Hospital and any staff members are authorized to release any/all information necessary or required to collect payment for services rendered. This may include information obtained during treatment for substance abuse or psychiatric services, including those protected by Code 42 of the Federal Regulations Part 2. In addition, I authorize normal access to my medical records by authorized Clinic personnel and/or health care providers. I understand that this authorization may be revoked at any time unless the Clinic and/or the Hospital has already released information in reliance on it.

All reports, records and dates pertaining to testing, care, treatment, reporting and research associated with HIV infection, AIDS and ARC (AIDS-related complex) shall be released as required under P.A. 488 as amended or if written consent specific to the disease or infection has been obtained by the patient. This authorization also allows release of the above medical information to private health insurers and third-party payers unless otherwise specified below.
Exceptions:

❑ AIDS. HIV, ARC ❑ Psychiatric ❑ Substance Abuse ❑ Hepatitis B

ASSIGNMENT OF INSURANCE BENEFITS

I hereby request and authorize the above named insurance company(s) to pay directly to the Clinic and/or Mclaren Medical Center Macomb any and all benefits due me under the terms of the policy number(s) indicated above. I will be responsible for any difference between my hospital expenses and the benefits derived from my insurance policy(s). I further agree that should the illness be such that it is not covered by said policy(s), I will pay the Clinic and/or Mclaren Medical Center Macomb any and all benefits due to me under the terms of said policy(s) with full power and authority to institute suit either in my name or on my behalf.

MEDICARE INPATIENT AND OUTPATIENT
PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediate or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I assign payment for the unpaid charges for certain in hospital physician services furnished by a specialist, or by physicians for whom the Hospital is authorized to bill. I understand that I am responsible for any health insurance deductibles and co-pay insurance.

ADULT PATIENTS

Adult patients are responsible for full payments at the time of service.

MINORS

The adult accompanying a minor and the parents (or guardians) are responsible for full payment. If my account balance should be entered into an audit program I agree to pay fees for that program.

Witness Date

Signature of pattent or other person acting on pattent's behalf

RelationshIp if other than patient