4050 West Maple Road, Suite 101
Bloomfield Township, MI 48301
248.885.8211 main
248.885.8357 fax
www.emcura.com
contactus@emcura.com
facebook.com/emcuramedical

Patient Registration

Office Use: Pt #:_____ **Copay:**_____

Date

Last Name_____First Name _____M.I. _____ DOB _____

Address _____ Apt or Space No _____

City _____ State _____ Zip _____ Marital Status M S W D other _____

Home Phone_____ Cell Phone _____ Work Phone_____

E-mail_____ ☐ Please check to opt out of health alerts or promotions Employer Name_____

Primary Care Doctor/Phone Number _____Referred by: _____

Pharmacy Name/Location _____ Race_____ Ethnicity: Hispanic/Latino☐ Non-Hispanic/Latino☐

Primary Language_____ Social Security Number _____

How did you hear about us? YP, Google, Bing, Sign, Yelp, Zocdoc, Word of Mouth, Beaumont Referral. _____

Responsible Party /Guarantor

Last Name_____First Name _____M.I._____ DOB _____

Address _____ Apt or Space No _____

City _____ State _____ Zip _____ Marital Status M S W D other _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer Name _____ Address _____

Emergency Contact

Full Name_____Telephone _____Relation _____

Insurance Information

Primary Insurance: Secondary Insurance:

Enrollee#:_____ Enrollee#:_____

Policy Owner Name_____ Policy Owner Name _____

DOB _____ Relationship _____ DOB _____ Relationship _____

Authorization to Release Information and Assignment of Medical Benefits

I hereby authorize Emcura Immediate Care to treat the above named patient. I authorize the release of medical information necessary to insurance claims concerning my illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits to be directly to Emcura Immediate Care. I understand that I am financially responsible for any amounts not covered by my health insurance.

Signature _____ Date _____

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Consent for Examination and Treatment

I hereby consent to and authorize the providers of **Emcura Immediate Care** to perform a physical exam and diagnostic tests which is deemed medically necessary for my treatment. I also consent and authorize Emcura Medical Immediate Care providers to prescribe a therapeutic treatment plan, which I shall follow. Unless I explicitly refuse, I consent to diagnostic procedure(s) ordered by the **Emcura Medical** providers despite the risk involved and/or complications that may occur, which will be explained to me at the time the procedure(s) is/are ordered. By providing **Emcura Medical** with your primary doctor's name, we reserve the right to communicate with your primary physician regarding each encounter.

Permit to submit medical claims

I request that payment of Medicare Benefits and other Insurance companies benefits be made on my behalf to **Emcura Medical.** I authorize the release of the medical information about me, which are necessary to process my claim, to the insurance companies with which I have coverage. I understand that it is my responsibility to provide complete and accurate information about my insurance(s) that I have. I authorize my insurance companies to release information about me that is related to my eligibility for benefits or coverage of specific services to **Emcura Medical** I understand that **Emcura Medical** agrees to accept the payment made by Medicare and/or other insurance companies as its full charge, I am only responsible for the deductible amount, co-pay or any amount for services not cover by my insurance.

Financial Responsibility:

This information is accurate and true to the best of my knowledge. I acknowledge and accept responsibility for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 120 days past due, a collection agency will be notified.

_____

Patient Signature or Legal Representative **Today's Date**

Print Name _____

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Patient Registration

HIPAA Notice of Privacy Practices for A3 Medical PLLC (dba) Emcura Immediate Care

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY A3 Medical PLLC DBA Emcura Immediate Care, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how **A3 Medical PLLC** may use and disclose your protected health information (PHI) to carry out our treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. Not every use or disclosure in a category will be listed. However, all of the ways **A3 Medical PLLC** is permitted to use and disclose information will fall within one of the categories.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by **A3 Medical PLLC** , our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: **A3 Medical PLLC** will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For Example: Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used by **A3 Medical PLLC** as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services that **A3 Medical PLLC** recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For Example: **A3 Medical PLLC** may need to provide your health plan information regarding services you received at our office so your health plan will pay us or reimburse you for the services.

Health Care Operations: **A3 Medical PLLC** may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example: **A3 Medical PLLC** may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Treatment Alternatives: **A3 Medical PLLC** may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: **A3 Medical PLLC** may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: **A3 Medical PLLC** may release medical information about you to a close personal friend or family member who is involved in your medical care or payment for your care, so long as you have not objected and it is reasonable for us to infer that such disclosure is in your best interest.

Special Purposes When Permitted or Required by Law: **A3 Medical PLLC** may disclose medical information about you as for special purposes when permitted or required by law, including the following: To avert a serious threat to health or safety against you, the public or another person. For public health and administrative oversight activities such as disease control, abuse or neglect reporting, health and vital statistics, audits, investigations, and licensure reviews. For organ and tissue donation and transplant to facilitate organ or tissue donation and transplant. For research purposes limited information may be disclosed as permitted by law. To workers' compensation or similar programs for the payment benefits for work-related injuries. To coroners, medical examiners and funeral directors to identify a deceased person, determine cause of death, or to carry out duties. To comply with court orders, judicial proceedings, or other legal processes related to law enforcement, custody of inmates, legal and administrative actions, and criminal activity. For U.S. military and veteran reporting regarding members and veterans of the armed forces of U.S. or foreign military. For national security and intelligence activities such as protective services for the President and other authorized persons.

State and Other Federal Laws: **A3 Medical PLLC** will comply with all applicable State and Federal laws. For example, under State law, there are more limits on the disclosure of HIV and AIDS information. We will continue to abide by all applicable state and federal laws.

Other Uses of Medical Information Require an Authorization: Other uses and disclosures of medical information not covered by this Notice or the laws that apply to **A3 Medical PLLC** will be made only with your written authorization. If you provide **A3 Medical PLLC** an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your

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authorization, **A3 Medical PLLC** will no longer use or disclose medical information about you for the reasons covered by the written authorization. You understand that **A3 Medical PLLC** is unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have many rights with regard to your medical information. If you wish to exercise any of these rights, you must submit your request in writing, unless otherwise noted.

Your Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. **A3 Medical PLLC** may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason that supports your request for an amendment. Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of certain disclosures **A3 Medical PLLC** made of medical information about you. Your request must state a time period. We may limit the time period to 6 years and to disclosures made on or after March 12, 2013. The first list you request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list.

Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information **A3 Medical PLLC** uses or discloses about you. For any services for which you paid out-of-pocket in full, we will honor any request you make to restrict information about those services from your health plan, provided that such release is not necessary for your treatment. In all other circumstances, we are not required by law to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Your Right to Request Confidential Communications: You have the right to request that **A3 Medical PLLC** communicates with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. If we maintain medical information about you in electronic format, you also have the right to obtain a copy of such information in electronic format and to direct us to transmit such information directly to an entity or person clearly, conspicuously, and specifically designated by you. We will not ask you the reason for your request. You may make this request in writing or verbally.

Right to Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Right to File Changes to this Notice: a Complaint: **Changes to this Notice:** If you believe your privacy rights have been violated, you may file a complaint with us. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Changes to this Notice: A3 Medical PLLC reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our offices and make copies available upon request.

Privacy Notice Contact Information: A3 Medical PLLC is required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please contact our office manager at (248)885-8211, or by email at contactus@emcura.com.

Acknowledgment of Receipt of Notice of Privacy Practices

My signature below indicated that I have been provided with a Copy of HIPPA Notice of Privacy Practices

_____

Patient or Legal Representative Signature Today's Date

_____

Please Print Patient Name Date of Birth