East Bay Medical Center | Patient Information | Patient ID #________

Patient Name ______________________________
Address ______________________________
____
City ______________ State ________ Zip ________

Home Phone: ______________ Work: ______________
Other Phone: ______________ Cell: ______________

Date of Birth ______________ S.S. # ______________

Marital Status S M W D

Email ______________________________

Race ________ ________ ________

If employed - Employer: ______________________________
Phone: ______________________________

Emergency Contacts ______________________________ phone # ______________
______________________________ phone # ______________

Guarantor (person responsible for billing) **Same as patient** Y N

If NOT Same as Patient: Name ______________ Date of Birth ______________
Address ______________ S.S. # ______________
City ______________ State ______________
Employer ______________ Phone ______________

Primary Insurance (first insurance) ______________________________

Policy # ______________ Group # ______________

Insured's Name ______________ relationship ______________
(name on the card)
Date of Birth ________ Phone ______________ S.S. # ______________

Secondary Insurance (second insurance) ______________________________

Policy # ______________ Group # ______________

Insured's Name ______________ relationship ______________
(name on the card)
Date of Birth ________ Phone ______________ S.S. # ______________

Pharmacy ______________ City ______________

Signature: ______________________________ Date: ______________

FINANCIAL ARRANGEMENTS
East Bay Medical Center

PATIENT NAME: ____

PAYMENT IN FULL OR CO-PAYMENT IS EXPECTED IN FULL AT TIME OF SERVICE.

PERSON TO BILL: Who will pay for services not covered by insurance?

NAME: ____

For your convenience, we offer the following methods of payment:

Cash **Personal Check** **HSA** **Flex Spending**

PATIENT AUTHORIZATIONS: (for Insurance Billing Purposes)
One-Consent for New and Established Patients:

Patient Name: ______________________________ SS# ______-_____-______

I request that payment of authorized benefits be made on my behalf to East Bay Medical Center for any services furnished me by that provider. I authorize my holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services.

Signature: ________________________________ Date: _________________

One-Consent for Patients with Supplement Insurance (*Medicare only*):

Patient Name______________________________ Medicare#::_______________

I request that payment of authorized Medicare benefits be made on my behalf of East Bay Medical Center for any services furnished me by East Bay Medical Center. I authorize any holder of medical information about me to release to any information needed to determine these benefits payable for related services.

Signature: __________________________________Date: _________________

AUTHORIZATION AND RELEASE

I hereby authorize you to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to East Bay Medical Center. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I am responsible for payment of all services rendered whether or not paid by insurance. Should this account be turned over to collections, I am responsible for all cost of collections and reasonable attorney fees.

Signature: __________________________________Date: _________________

NOTICE OF PRIVACY ACKNOWLEDGMENT
East Bay Medical Center

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct the record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information by contacting our Privacy Officer at (989)366-1515. Our Notice of Privacy describes in more detail how your health information may be used, disclosed, and how you access your information. By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Signature: ________________________________ Date: _______________
(Or Legally authorized individual signature)

Printed Name: _____________________________ Relationship: ______________

_____ Good faith attempt has been made to provide the patient with our Notice of Privacy Practices.

Employee Signature: _________________________________ Date: ___________

Witness Signature: __________________________________ Date: ___________

CONTACT INFORMATION

Please mark all that apply:

_____ You may contact me at my home telephone _____ You may contact me at my work phone

_____ You may leave a detailed message at my home _____ You may leave a detailed message at work

_____ You may leave a message to confirm appointments or to return our call

_____ You may contact me by mail _____ You may discuss with my spouse
NAME: _________________

_____ You may contact me by e-mail, my e-mail address is: ____________________________

EAST BAY MEDICAL CENTER, P.C.
1401 SHORT DRIVE
P.O. BOX 19
PRUDENVILLE, MI 48651
PHONE: 989-366-1515 FAX: 989-366-1501

Opioid / Narcotic / Controlled Substance Agreement

I____ agree to the following:

1) I agree to use ____ Pharmacy, located at, ___________________________________, for filling prescriptions for all of my pain medicine. I also agree that Suzanne Blanchard is the only provider who will prescribe my pain medicine.
2) Medication is taken as prescribed. The dose and frequency of medication must not be altered unless discussed with the provider.
3) A provider sees you in the office no less than every two months for a symptom and medication review. If you fail to keep your appointments, the provider will not continue to refill your medication, based upon their professional judgment.
4) Patient must notify the provider if additional medications are prescribed (i.e. by the emergency room, hospital or other providers of health care.)
5) It is the patient's responsibility to safeguard the medication at all times, under all circumstances. This includes being lost or stolen.
6) The patient must comply with other treatments ordered, such as but not limited to radiology, laboratory testing, physical therapy, counseling, and referral to specialists.
7) All prescription refills require a minimum 48 hours notification (this does not include weekends or holidays).
8) I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medicine.
9) Possession of, conviction of or positive drug screening of illicit substances is a violation of this agreement. If this contract is broken your insurance company is notified.
10) Long acting medications are designed to work slowly. Serious side effects, including respiratory arrest and death may occur if the tablet, capsule or patch is crushed, broken, chewed, injected or otherwise ingested. Taking the medication in such a way as to attempt to become intoxicated from the substance or abuse of the medication in any form is a violation of this agreement.
11) Short-term side effects of medication may occur including nausea, headache, and sedation. These side effects generally subside in a week or two. Law enforcement can prosecute people who drive or operate equipment while under the influence of medications. East Bay Medical Center is in no way responsible or liable for your actions while using these substances.
12) Medication and alcohol should never be combined for any reason.
13) Patient agrees that he/she will not share or sell the medications to anyone, nor will they accept medications from others.
14) I will bring all unused pain medicine to every office visit.
15) Non-compliance with any of the items in this agreement may require cessation of the substances, detoxification if necessary with referral to substance abuse specialist, and/or dismissal from East Bay Medical Center.
16) Any verbal abuse with any staff member will not be tolerated and may result in dismissal from East Bay Medical Center.

Your signature indicates you have read and understand the above information. You will be given a copy of this form and the original will be placed in your file.

PATIENT: ______________________________ DATE: ______________________

WITNESSED SIGNATURE: __________________________ DATE: ________________

PROVIDER SIGNATURE: ____