Emerge Health and Wellness
1397 N. Monroe St.
Monroe, MI 48162
(734) 243-3420 Fax: (734) 457-4570

All sections must be completed, or your insurance cannot be billed!

SS#: _____ **Name:** _____
LAST FIRST MIDDLE INITIAL

Address: _____ **Birth Date:** _____
NUMBER STREET CITY STATE ZIP

Gender: _____ **Home Phone:** _____ **Cell Phone:** _____

Marital Status: _____ **Race:** _____ **Ethnicity:** _____ **Language:** _____

Employed? Full Time Part Time Not Employed Retired **Student? Full Time Part Time Not a Student**

Employer: _____

Emergency Contact

Name: _____ **Relationship:** _____ **Phone:** _____

Birth Date: _____

Insurance Information:

Subscriber: _____ **Birth Date:** _____ **Employer:** _____

Primary Insurance: _____ **Contract#:** _____ **Group#:** _____

Subscriber: _____ **Birth Date:** _____ **Employer:** _____

Secondary Insurance: _____ **Contract#:** _____ **Group#:** _____

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy.
Although we try to stay aware of these changes, it is not always possible.
IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE.
Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.
Please remember, your insurance policy is between you and your insurance company, and not with the insurance company and your doctor.

Signature: _____ **Date:** _____

I authorize the release of any medical information necessary to process my claim and request payment of medical benefits to Emerge Health and Wellness.

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Medical Records Release Request

Authorization to Disclose Health Information

Patient Name: _____ **SS#:** _____

Patient Address: _____ **DOB:** _____

_____ **Phone:** _____

Fill out complete address of physician or we cannot send or request medical records:

Physician/Organization From:	**Physician/Organization To:**
_____	_____
_____	_____
_____	_____

Information to be disclosed (Include dates where appropriate):

[ ] Entire Chart (Standard two years of information will be transferred unless otherwise indicated below)
or

[ ] Problem List	[ ] Immunization Record	[ ] Progress Notes
[ ] Lab Reports	[ ] X-Rays/EKG/Tests	[ ] Living Will
[ ] Billing Statements	[ ] Other (Specify) _____	

Purpose of Disclosure:

[ ] Continuation of Medical Care	[ ] Attorney
[ ] Payment of Claims	[ ] Personal Use

Information should be delivered via (Select one):

[ ] Pick Up [ ] Mail to Address Above Fax to: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected. I understand that the specified information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. This authorization will expire six (6) months from the date of my signature unless I revoke this authorization prior to that time.

Signature of Patient or Guardian: _____ **Date:** _____

If you are the legally authorized representative of the patient, describe the scopes of your authority (attach necessary proof)

Medical History

Name: _____ Date: _____

List medications you are currently taking. Include both prescriptions and over-the-counter drugs, as well as any supplements you use regularly.

Medication Name	Frequency	Dose	Purpose

List any medical conditions and all past surgeries.

List any allergies and your reactions.

Allergy	Reaction

Medical History

Name: _____ Date: _____

Tobacco Use

_____ Non-User

_____ Former, Quit Date _____

_____ Current User

Most Recent HGB A1C _____%

Date _____

Last Eye Exam Date _____ Facility _____

Have you fallen in the past year? _____

Last Mammogram Date _____ Facility _____

Last Colonoscopy Date _____ Facility _____

Flu Shot Y N Date _____

Pneumonia Vaccine Y N Date _____

Prevnar 13 Vaccine Y N Date _____

Covid 19 Vaccine Y N 1st Dose Date _____ 2nd Dose Date _____

Booster Date _____

Please list all specialist physicians you are actively seeing.

Name	Specialty

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Privacy Policy Statement Acknowledgement

Patient Name: _____ Birth Date: _____

Social Security #: _____
(last 4 digits)

I have received a copy of the Emerge Health and Wellness Privacy Policy Statement. Which includes electronic access to medication history, I understand that Emerge Health and Wellness has the right to change its Privacy Policy Statement from time to time and that I may contact Emerge Health and Wellness at any time to obtain a current copy of the Privacy Policy Statement.

Patient Signature: _____ Date:_____

Legal Representative: _____ Date:_____

Relationship to Patient: _____

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Patient Financial Responsibility Statement Acknowledgement

Patient Name: _____ Birth Date: _____

Social Security #: _____
(last 4 digits)

By signing below, each of the undersigned acknowledgement that : (i) I have been provided a copy of the Emerge Health and Wellness Patient Financial Responsibility Statement; (ii) I have read, understand and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Emerge Health and Wellness for the below patients' care and treatment, including copayments and deductibles, as required for provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third party will be credited on the patients' account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account; (vi) if I fail to make any of the payment(s) for which I am responsible in a timely manner, I will be responsible for all the costs of collecting the money owed.
I further agree that a copy of this Patient Responsibility Financial Statement shall be as valid as the original.

Once I have signed this agreement, whether by original, facsimile or electronic signature, I agree to all of the terms and conditions contained herein and the agreement shall be in full effect.

Patient Signature: _____ Date: _____

Legal Representative: _____ Date: _____

Relationship to Patient: _____

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MEMO OF UNDERSTANDING

Thank you for choosing our medical practice as your home base for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuing, and personal medical care. For this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

PHYSICIAN RESPONSIBILITIES

*Listen to you as to your health care matters, and encourage a culture of open, full, and frank communication
*Provide counsel and information regarding the different treatment plans for chronic conditions or prevention programs.
*When possible, provide convenient option including electronic access for non-urgent communications for scheduling office visits and follow up visits, and for obtaining test results and referrals.
*Provide flexible and expanded office hours, schedule appointments within a reasonable time, and see Patient as closely as reasonably possible to scheduled appointment time.
*Provide telephone availability to Physician for urgent communication 24 hours per day, 7 days per week.
*As technology develops, provide convenient options for non-urgent communications between Patient and physician including post-hospital support, follow up visits and consultations.
*Use a team approach to health care by providing access to other clinicians and health care institutions when and where appropriate.
*Coordinate and integrate care provided by my practice team and other clinicians and health care institutions effectively so as to avoid duplicate, delay and error.
*Communicate test and treatment results promptly and correctly.
*Provide information, recommendations, and advice regarding preventative care, maintaining wellness, self-management direction, and counseling.
*Send reminders of the need for follow up care and prevention care.
*Maintain clinical information in a format that allows ready search, retrieval, and information transfer while protecting privacy and confidentiality, including participating in the development and maintenance of standardized electronic health privacy and confidentiality, including participating in the development and maintenance of standardized electronic health records (EHR) and patient registries.
*Coach the medical home base staff in the responsibilities described above.

PATIENT RESPONSIBILITIES

*Communicate openly, fully, frankly, and proactively with Physician and Physician's staff.
*Be an active participant in the development with Physician of action plans and treatment plans for the Patient's acute or chronic condition and follow agreed-upon treatment plans.
*Provide Physician with feedback regarding Patient's treatment plan.
*Appear on time for appointments, procedure, and other medical tests at Physician's office, and timely submit materials, samples, and information requested by Physician.
*Schedule and attend follow-up appointments at intervals suggested by Physician.

*Involve yourself in Physician's and other health care professionals' recommendations with request to maintenance or improvement of Patient's health and wellness.
*Participate in action planning and goal setting with respect to maintenance or improvement of Patient's health and wellness.
*Participate in developing and maintaining a comprehensive health record by authorizing delivery and circulation of clinical information to and from clinicians and health care institutions.

Once you have completely read this memo of understanding please sign your name below to acknowledge your understanding.

Patient Signature: _____ Date:_____

Legal Representative: _____ Date:_____

Relationship to Patient: _____

Physician Signature: _____ Date:_____