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: Hispanic/Latino Non-Hispanic/Latino**

Language: _____ **Student? Full Time Part Time Not a Student**

Employed? Full Time Part Time Not Employed Retired 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)

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Financial Policy – Effective January 1, 2026

At Emerge Health and Wellness, we are committed to providing high-quality care and appreciate the privilege of serving you. To ensure clarity and avoid misunderstandings, the following outlines our financial expectations.

1. **PAYMENT:** Payment is due **before services are provided.** The Practice accepts cash, check, and debit/credit cards. A **4% processing fee** applies to all credit/debit card payments except FSA/HRA/HSA benefit cards. Patients are responsible for all deductibles, copays, coinsurance, and any non-covered services. **Self-pay patients must pay in full at the time of service.**

   Payment Terms:

   - Copays, expected coinsurance, and deductible amounts must be paid before services are provided.
   - Unpaid balances of **$50.00 or less** must be paid in full before services are provided.
   - For balances **over $50.00** and **less than 180 days from the date of service**, a minimum payment of **17% of the total balance** is required before services are provided.
   - For balances **180 days or older from the date of service**, the **full balance** must be paid before services are provided.
   - Patients may set up a payment plan through our online payment portal for eligible balances. Payment plans must be arranged **in advance** of your appointment and may not exceed **6 months**; otherwise, the payment requirements listed above will apply.
2. **INSURANCE & BILLING:** As a courtesy, we will file claims with your insurance carrier. It is your responsibility to ensure your insurance is active and to understand your benefits, including deductibles, copays, coverage limits, and out-of-network rules. Our providers may not participate with all insurance plans, and some services may not be covered. If insurance denies or does not fully cover a service, you are responsible for the remaining balance.
3. **ASSIGNMENT OF BENEFITS:** By receiving care at our practice, you authorize your insurance benefits to be paid directly to Emerge Health and Wellness for services provided.
4. **FORMS:** Our office charges a **$25.00 fee** for any forms your provider must complete. This fee is **not billable to insurance** and must be paid **before forms are completed**.
5. **MEDICAL RECORDS:** Requests for medical records may incur a fee in accordance with state law. Fees must be paid before records are released.
6. **LABS & OUTSIDE SERVICES:** Lab work, imaging, and diagnostic testing performed by outside facilities may result in separate bills. It is your responsibility to verify coverage with your insurance provider.
7. **RETURNED PAYMENTS:** Returned checks or failed electronic payments are subject to a **$35 fee**. Future payments may be required by cash, credit card, or certified funds.
8. **DELINQUENT ACCOUNTS / NONPAYMENT:** Accounts that remain unpaid **180 days from the date of service** may be referred to a collection agency. Any reasonable fees associated with collection efforts will be added to your balance, and you agree to be responsible for those additional charges.
9. **POLICY UPDATES:** Emerge Health and Wellness may revise this Financial Policy at any time. Updated versions will be made available on our website and at the front desk.

_____ _____

Signature of Patient (or Guarantor) Date

_____

Print Name

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Privacy Policy Statement Acknowledgement

Patient Name: _____ Birth Date: _____

I have received a copy of the Emerge Health and Wellness Privacy Policy Statement. 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: _____

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