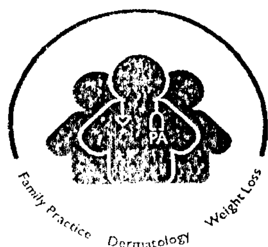

David Barney Family Medicine
6690 Crossings Dr. SE suite C, Grand Rapids, MI 49508

p: (616) 600-1885
f: (616) 600-2782

PATIENT REGISTRATION FORM

Name:____ Date of Birth: ______________

Sex: ☐ Male ☐ Female Social Security #: ____________________________________

Parent / Guardian:__________________________ Soc. Sec. #:_______________________

Home Address:

____

City / State / Zip:

Phone #: ☐ Home ____________ ☐ Work ______________ ☐ Mobile ________________
(Please check your preferred primary phone number to be reached at)

E-mail Address: ____

Employer:____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's name: ____

Referred to David Barney Family Medicine by: _____________________________________

Emergency Contact: _______________________ Relationship: _____________________

Phone #: Home ___________________

Work ___________________ Mobile ___________________

Permission to treat & release records: I authorize David Barney Family Medicine to provide medical treatment to myself of the above-named patient, for whom I am legally authorized to obtain medical treatment. I further authorize David Barney Family Medicine to furnish medical information, including diagnoses and copies of my medical record, to my insurance company in order to determine liability for payment and to obtain reimbursement on my behalf. I assign benefits payable, to which I am entitled, directly to David Barney Family Medicine. I understand that during the course of my treatment by David Barney Family Medicine, the services of a specialist, hospital, laboratory, or other medical provider may be required. By signing this authorization, I give permission to David Barney Family Medicine to release

any part of my medical record that would be pertinent to treatment and/or evaluation by such a medical provider. In addition, I give permission to David Barney Family Medicine to release any demographic or insurance information (including my Social Security Number if required for billing or payment purposes) to such a medical provider. I have read and understand the above information. In addition, I agree that a copy of this authorization shall be valid as the original. This authorization may be revoked at any time by written request.

I also understand that this office may leave appointment reminders, lab and/or x-ray results, and billing questions on the phone numbers listed on this form or in the computer system.

PATIENT CENTERED MEDICAL HOME (PCMH) Patient / Provider Agreement: Good communication between patients and physicians is the key to better outcomes. We are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

<u>Our Responsibilities to You</u>:

- Respect you as an individual – we will not make judgments based on race, ethnicity, religion, gender, age, mental or physical disability, sexual orientation or genetic information
- Respect your privacy – your medical information will not be shared with anyone else unless you give permission or as required by law
- Provide the best possible treatment and advice based on current medical evidence – we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
- Manage your health status, including well person/preventive care as well as treatment for acute and chronic diseases and provide information regarding appropriate community services
- Provide you timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed.

<u>What We Ask of You</u>:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your doctor about any changes in your health and well-being
- Take your medicine as ordered and follow your doctor's advice - if you are unwilling or unable to do so, be honest with the doctor
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor first with all problems, unless you have a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans
- Request information about community services related to my health needs
- If medical or community services are performed outside of this PCMH office, request all information to be sent to the office.

____ Date

Signature of Patient (or Parent/Guardian)