US Healthcare MI, PC

P.O. Box 430328, Pontiac, MI 48343
P: (248) 688-5900 F: (800) 383-1059 Email: ushpgh@gmail.com

Patient Name:_____
Last MI First

D.O.B:_____/____/____ **Sex:** M / F **SSN:**_____ **Marital Status:** _____

Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ **Email:**_____

Emergency Contact Name: _____**Phone:**_____

Address:_____**Rel:**_____

Auto Insurance

Name:_____ **Phone:**_____
Claim Number:_____**DOA**:_____
Adjustor:_____**Phone:**_____
Attorney:_____**Phone:**_____

Medical Insurance:_____**Effective date:**_____
ID Number: _____**Group #:** _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to US Healthcare MI, PC. I also authorize US Healthcare MI, PC to take my photo and other photos of my injuries/medical issues for documentation, education and research.

X_____ _____
Patient Signature **Date**

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Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

With your consent, the practice is permitted by federal privacy laws to make uses and discloses of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:

- Request restriction on certain uses and disclosures of your health information by delivering the request in writing to our office.
- We are not required to grant the request but we will comply with any request granted.
- Request that you be allowed to inspect and copy your health record and billing record- you may exercise this right by delivering the request in writing to our office.

Our Responsibilities

- Maintain the privacy of your health information as required by law.
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you; abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office administrator.

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

X_____ _____

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Authorization to Release Healthcare Information

Patient Name: _____ **Date of Birth**:_____

Previous Name: _____ **SSN**: _____

Address: _____

City:_____ **State**:_____ **Zip**:_____

I request and authorize _____ to releases healthcare information of the named above to:

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition or dates:

  _____

  _____
- All healthcare information:

  _____
- Other:_____

_____Yes _____ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

X_____ _____

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Patient Consent & Agreement to Treat and Pain Management

1. **Medical Examination and treatment billing this insurance**

I hereby consent and authorize the physician from US Healthcare MI, PC to perform initial detailed consultation (history and examination) and interval consultation later on periodically for my health care. I acknowledge that I have received the notice of privacy practice document to safeguard my medical information and diagnostic procedure(s) ordered by my physician despite the risks involving complications that may occur, which may be explained to me at the time the procedure(s) are ordered. I request that payment of insurance benefits be made on my behalf to US Healthcare MI, PC for any services provided by those physicians or by my physician staff upon my physician's orders.

2. **Controlled Substances prescription (uses, adverse & restrictions)**

I will receive controlled substances (pain medication) from one physician only and from one pharmacy will confirm my identity whenever asked i will take the medications as directed and it will be in my possession at all times. I will preserve the bottle at the time of refill when needed. I also consent for blood/ urine tests to check the level of drugs. The medications have adverse effects on drowsiness, false feelings or well being, headache, confusion, dry mouth, nausea, decreased urination, constipation and neuro-skeletal muscular weakness, etc., thus operation o machinery or driving of vehicle is prohibited.

Pharmacy:_____ Phone:_____

3. **Tylenol Toxicity (Liver Damage)**

Tylenol (Acetaminophen) has been known to cause cirrhosis of the liver if more than 3 mg is taken chronically. Regular and chronic use of Tylenol has great potential of causing cirrhosis of the liver (hardening and dysfunction) and there is no guarantee that less Tylenol use chronically is safe and the liver damage caused may be difficult to detect in the beginning and may be to late when known as chronic. Patients taking controlled substances- opioids are usually taking Tylenol also and with this medication over the counter. Tylenol in combination with other meds should be avoided and taken for other illness like flu, cold, headache, etc. Though you are getting relieved of pain by Codeine/Tylenol but at the same time you are not supposed to damage your liver by excessive dosage, so less harmful therapy should also be considered.

4. **Violation of Agreement (Controlled Substances may be denied)**

I agree that in case of violation of this consent and agreement (not taking medication as prescribed, taking medication from other physicians and different pharmacies as reported in MAPS and otherwise, not keeping the medications with me and not agreeing of other therapy options): I will not be given any controlled substances and may be discharged from the services.

Copy of above received by me

X_____ _____

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Lein and Medical Authorization

I hereby grant a lien to US Healthcare MI, PC, (hereafter collectively referred to as "Lien Holder") This lien applies to any settlement, judgement, garnishment, arbitration award, and insurance claim or payment (hereafter collectively referred to as "actions") regardless of whether such actions relate to *lien holder's* bills. The lien is for the full amount of the *lien holder's* bill relating to me for medical care, products, services or accommodations (collectively hereafter referred to as *treatment)*

I acknowledge that receipt, adequacy and sufficiency if the consideration for this lien in the amount of $1.00, and other valuable consideration, including but not limited to one or more of the following: *lien holder* has provided *treatment* to me in the past without timely payment from me, *lien holder* will in the future provide *treatment* to me for which I am not realistically able to make timely payment in full or for which *lien holder* is realistically insecure that i will be able to pay timely in full. *Lien holder* has, for any period of time however short, refrained from collecting the balance due from me.

I acknowledge that granting this lien does not affect or diminish in any way my personal obligation to the *lien holder* to timely pay for *treatment*.

I hereby direct my attorney(s) and agent(s) to withhold funds from any *action,* to first pay the lien holder the full amount of the balance owing by me as specified by the lien holder, or as much as possible with the funds available, and to refrain from making any other disbursement of funds, including disbursements to me or on my behalf, until the lien is paid in full. The directive to my attorney is irrevocable. I promise to immediately notify lien holder of the name of m attorney presently, and any new attorneys in the future.

I hereby authorize lien holder to use and furnish my medical records and medical information to anyone for the purpose of collecting amounts owing by me, including but not limited to insurance companies, and their attorneys or agents; and i also authorize lien holder and it attorneys and agents to testify or to otherwise reveal my medical records and information in any actions to collect balances owed by me.

I have read and understand this document. By signing below, i agree to it. I understand that if I refuse to sign this agreement i will not be deprived presently of any emergency treatment I may need.

X_____ _____ _____

Patient Signature **Witness Signature** **Date**

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Financial Hardship Form

The undersigned Physician/ PA saw and evaluated

_____

The patient declared that he/she is on a Financial Hardship and will be unable to pay any co-pays or additional charges related to his/her medical insurances and other services offered by our practice.

According to this statement the patient should not be charged any co-pays for the medical services rendered by our company.

X_____ _____

Patient Signature **Date**