South Valley Internal Medicine, P.C.

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Long Island Medical & Cosmetic Dermatology, P.C. or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER:_(_____)_____

MEDICAL HISTORY

Patient: _____ Date taken: _____

Reason for today's visit: _____

Are you allergic to any medications? ❑ Yes ❑ No If yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

History of Diseases

Do you have now, or have you ever had diseases or conditions of:

Lungs:	Yes	No
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Vascular:		
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Pacemaker	❑	❑
Phlebitis	❑	❑
Mitral Valve Prolapse	❑	❑

Other Systemic:	Yes	No
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Stomach	❑	❑
Bowel	❑	❑
Hepatitis or Yellow Skin	❑	❑
Glaucoma	❑	❑
Arthritis/Joint Deformity	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑
Artificial Joints	❑	❑

Do you drink alcohol? ❑ Yes ❑ No If Yes, _____drinks per day

Do you use IV drugs? ❑ Yes ❑ No If Yes, what?_____ How much? _____

Have you been or have you ever been exposed to any infections disease(s)? ❑ Yes ❑ No

Have you ever had dental anesthesia (Novacaine)? ❑ Yes ❑ No Any bad reaction? ❑ Yes ❑ No

Do you prophalax before dental procedures? ❑ Yes ❑ No

Do you have a latex allergy? ❑ Yes ❑ No

Skin:

When you are exposed to sun do you: ❑ Tan only ❑ Tan and burn ❑ Burn

Have you ever had skin cancer? ❑ Yes ❑ No

Has anyone in your family had skin cancer / melanoma? ❑ Yes ❑ No If yes, who?_____Type?_____

Do you have a history of any specific skin diseases? ❑ Yes ❑ No

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had: _____

Please answer the following questions:

A. Do you smoke? ❑ Yes ❑ No If yes, how much: _____

B. Do you bleed easily: ❑ Yes ❑ No

C. (Women) Are you pregnant? ❑ Yes ❑ No Due Date: _____

D. What is your occupation? _____

E. What are your hobbies? _____

Completed by: ❑ Patient
❑ L.P.N. - R.N._____
Initials

Reviewed by: _____
Signed by Physician Date

SOUTH VALLEY INTERNAL MEDICINE, P.C.
Jonathan Lovy, D.O., F.A.C.O.I
2674 West Jefferson Ave. Ste 1, Trenton MI 48183
Phone (734) 365-8801 Fax: (734) 365-8802

Protected Health Information Release Form:

Patient Name: _____ Date: _____

(1) Concerning matters of my health, I give permission for Dr. Lovy a member of his staff to speak with:

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

Signature of patient: _____

Witness: _____

Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to South Valley Internal Medicine, P.C.

I understand that I am financially responsible for all services rendered and for the following reasons:

If: 1) I do not have the proper referral at the time of service 2) I have not provided the correct address 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company *(This applies to present and future visits).*

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. In the event that your account must be turned over to collections, a **$25.00 Collection Fee** will be added to your account. A **$35.00 NSF** fee will be assessed if your check is return with insufficient funds.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan. A **No Show Fee of $25.00** will also be added to your account for same day cancellations.

Patient or Responsible Party Signature_____Date_____

HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At South Valley Internal Medicine, P.C. we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM If you have concerns or would like additional information, you may contact the Practice Manager at (734) 365-8801.

Signature_____ Date_____

2674 West Jefferson Ave. Ste 100, Trenton, MI 48183
Ph: (734) 365-8801 Fax: (734) 365-8802

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to SVIM by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize South Valley Internal Medicine to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____ (Your former doctor)
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ All (relevant medical, outpatient and diagnostic testing records or specific only)

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date OR
Date of Birth:_____

_____
Signature of Witness Date

(12/2019)

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

I, _____, understand and voluntarily agree, that this controlled medication may cause addiction and is only part of the treatment for my recorded condition.

THE GOALS OF THIS MEDICINE ARE:

- To improve my ability to work and function at home
- To help my condition(s) as much as possible without causing dangerous side effects.

I HAVE BEEN TOLD THAT:

- If I drink alcohol or use street drugs, I may not be able to think clearly, and I could become sleepy and risk personal injury.
- If I or anyone in my family has a history of drug or alcohol problems, there is a higher change of addiction
- If I need to stop this medication, I must do it slowly or I may get very sick

I AGREE TO THE FOLLOWING:

- I will keep the medicine safe, secure and out of the reach of children. I will also dispose of it properly by turning it in to SVIM office or at any designated drop off locations. I will not flush it down the drain or throw it into regular garbage.
- I am responsible for my medications. I will not share, sell, or trade my medicine. I will not take anyone else's medicine
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine/ prescription WILL NOT be replaced if it is stolen, or used up sooner than prescribed
- I will keep all appointments recommended by my doctor (e.g., primary care, physical therapy, mental health, pain management, etc.)
- I will always treat the staff at the office with respect. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.
- I will comply with drug testing required so that I am properly monitored and safely taking the medications.
- I agree to come in for my appointment, depending on the medication, every 30 or 60 days, to be re-evaluated for conditions I have and medications that I am taking.
- I agree to <u>only</u> get my controlled medication from my providers at South Valley Internal Medicine.

REFILLS:

Refills for controlled medication will be made only during office hours. You will be given a hard copy script to take to your pharmacy. We will NOT fax or call in and controlled medication. If my provider is not available, I agree to see another SVIM provider in order to comply with the required visits. I will make my next appointment to make sure that I do not run out of my medication.

Patient Signature: _____ Date: _____

South Valley Internal Medicine, P.C. – OFFICE POLICIES

OFFICE HOURS: Our office is open Monday – Friday, 9:00 am – 5:00 pm. With extended hours on most Tuesdays. Please note: the office phones are off daily at 4:30 pm except for Tuesday, extended to 5:30 pm

Walk-In/ Same day appointments: We have open slots daily, for the providers who are available that day. These slots are limited, so please call by 9:00 am to secure a same day appointment. We are happy to offer you an open slot that will meet your schedule. Please take advantage of our Tuesday, extended hours for your convenience.

Office Closure: At times, our office might close for circumstances that are beyond our control including, but not limited to inclement weather. The following procedures are used to inform our patients.

- If you are scheduled for an appointment, you will receive an automated message by phone.
- Closing will be displayed on our Facebook page. Please follow us on Facebook.

After Hours/Emergencies: In the event of an emergency, please call 911 immediately. If you are unsure about whether to call 911, please call the office and follow the prompts to connect you to the Physician on call.

Cancellation: We require a 24-hour notice of cancellation prior to your appointment. This allows us to that time slot to another patient. If you must cancel on less than 24 hours' notice, please call as early as possible.

No Show: A "no show" is when a patient misses an appointment without cancelling it within 24 hours in advance. Unfortunately, "no-show" inconveniences those patients who need access to medical care in a timely manner. A failure to be present at the time of a scheduled appointment will be recorded in our medical chart as a "no show". A No-show administrative fee will be billed to your account. You will be notified