Patient's Last Name ________________________________ First Name________________________________ MI______

Sex: M F Date of Birth _________________________Social Security #_______________________________________

StreetAddress ____Apt __________ PO Box ______________

City _______________________ State____________ Zip ___________Email__________________________________

Phone Number: (Circle: Cell/Home) _______________________________Contact Preference: circle: email/phone/mail

Emergency Contact Name ____ Relationship _____________________

Emergency Contact Phone Number: (Circle: Cell/Home) ______________________________Birth Date_____________

Preferred Pharmacy _______________________________City_____________________ Cross road_________________

Primary Care Physician ____________________________ Primary Care Physician Phone #: ________________________

Primary Insurance_________________________Subscriber's name_________________________________ ________

Subscriber's date of birth__________________________Relationship to Insured _______________________________

Subscriber's Address ____

For TRICARE Only: Sponsor's Social Security Number_________________ Secondary Insurance____________________

Subscriber's Name ___________________ Subscriber's Date of Birth ________ Relationship to Insured _____________

Most laboratory services will be done at an outside lab (i.e. St Joseph Mercy). Please be aware that there will be a separate bill from the lab for these services. If your insurance company requires that your lab tests be done at a designated facility, you will need to inform us of this each time lab tests are being ordered.

I acknowledge my rights as assigned through the Notice of Privacy Practices. A copy of this notice is available upon request. I also request that payment of authorized insurance carrier benefits be made on my behalf to Howell RediCare for any services furnished by this provider. I authorize any holder of medical or other information about me to release to any information needed to determine their benefits for related services. I also authorize RediCare to access my medication history through the electronic pharmacy network.

Signature____Date __________________

I give my permission for my medical information to be released to the following individuals/Employer/Work Comp

Name:____ Relationship:_____________________________________

We do NOT participate with any form of Medicaid.

Why I might get a bill when I have insurance: Not all of the services we provide are covered by all insurance carriers. We makeevery effort to inform you if we believe a service may not be covered, however, itis your responsibility to know the coverage limitations of your insurance contract.Since we do contract with several insurance companies, it is impossible for us toknow the requirements of each individual policy.Your insurance policy is an agreement between you and your insurance company.You are responsible for your account. You are also responsible to know your own insurance policy, its benefits and requirements. We do not determine the amountof coverage you will receive; your insurance company does this. Any questionsyou may have concerning your benefits should be directed to your insurancecompany's Member Services Representative.Please inform our office of any changes in your insurance since your last visit.

I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES MY INSURANCE COMPANY DOES NOT COVER

SIGNED____**DATE**________________________