



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 make every effort to inform you if we believe a service may not be covered, however, it is your responsibility to know the coverage limitations of your insurance contract. Since we do contract with several insurance companies, it is impossible for us to know 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 amount of coverage you will receive; your insurance company does this. Any questions you may have concerning your benefits should be directed to your insurance company'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** _____