Charles Lilly, MD, PC, Michael Moutsatson, DO, PLLC
Ryan Lilly, MD, Kelsey McConnell, PA-C, Carrie White, PA-C

Today's Date: ___/____/____

PATIENT DEMOGRAPHIC INFORMATION

Patient Legal Name: _____
Last First Middle Initial

Legal Sex: M F **D.O.B.**_____/_____/_____ **Age**_____ **Patient's Social Security #**_____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Gender queer ☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Patient Phone _____ ☐ Home ☐ Cell **Patient Phone** _____ ☐ Home ☐ Cell **Email Address** _____

Do you prefer that we send your billing statements ☐ Mail ☐ Text ☐ Email (emailing & texting are secure sites)

Patient Current Address:_____
Street/Road/PO Box/Apartment City State Zip

Name of Responsible Party, (If different than patient, or if patient is a dependent) _____
Last First Middle Initial

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____ ext # _____ Cell Phone: ( ) _____ - _____

Billing Address (What address would you like us to send your billing statement to?)

Street/Road/PO Box/Apartment City State Zip

Employment status: Full time Part time Unemployed Disabled Retired Student

Referring Physician: _____ **Primary Care Physician:** _____
M.D./D.O./D.C. M.D./D.O

ALL PATIENTS: Emergency contact: _____ Relationship to patient:_____
(Last) (First) (Middle initial)

Home Phone: ( )_____-_____ Work Phone: ( )_____- _____ ext. #_____ Cell Phone: ( )_____ -_____

All Patients: **Release of protected health information:**

I authorize the release of my protected health information (PHI) to the persons listed below. (e.g., spouse, parent, etc):
Name: _____Relationship:_____
Name: _____Relationship:_____
Name: _____Relationship:_____
Signature:_____ **Date:**_____
(Patient, Parent or Legal Guardian if patient is a minor)
Witness:_____**Date:**_____
(CMO Representative)

All Patients: **Notice of privacy practices acknowledgement:**

Dr's C. Lilly, Moutsatson, R. Lilly, K. McConnell, PA-C and C. White, PA-C have made their "Notice of Privacy Practices" document available to me.

Signature:_____ **Date:**_____
(Patient, Parent or Legal Guardian if patient is a minor)
Witness:_____**Date:**_____
(CMO Representative)

All Patients: **Assignment of benefits/Financial responsibility/information release all patient:**

I, the undersigned patient, parent or guardian of a patient, authorizes payment of medical benefits to Dr. C. Lilly, Dr. Moutsatson, Dr. R. Lilly, K. McConnell, PA-C or C. White, PA-C for any services furnished to me by them. I understand that I am financially responsible for any amount not covered by my insurance carrier (i.e. co-payments, deductibles, co-insurance or non-covered services). I also authorize you to release to my insurance carrier or their agents(s), information concerning health care, advice, or treatment provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

Signature: _____**Date:** _____
(Patient, Parent or Legal Guardian if patient is a minor)

Witness:_____**Date:**_____
(CMO Representative)

Today's Date: ___/____/____ **Patient name:** _____

All patients:

Is this injury/illness related to Auto Accident: Y N Workers compensation: Y N Other accident/injury: Y N

Other legal liability injury: Y N None: _____

I, the undersigned, agree that my illness or injury is not related to an Automobile accident, Worker's Compensation, slip and fall, or any other accident or injury claim in which a carrier other than my health insurance should be billed.

Signature: _____ Date: _____/_____/_____

(Patient, Parent or Legal Guardian if patient is a minor)

How did you hear about us?

Facebook _____ Google Advertising ____ Family Friend ____ Provider Office ____ Other (please describe) _____

*****Please present all insurance cards with this completed form to the Receptionist*****

1. PRIMARY INSURANCE INFORMATION

BCBS MI____BCBS *other state*____ MI Medicaid ____ Medicaid HMO ____ Regular Medicare ____Medicare Advantage Plan ____

Other insurance: _____ Auto_____ Workers Comp _____ None____

Primary insurance office visit Co-pay amount: (select one) Flat fee Co-pay: $_____._____ or Percentage Co-pay _____%

Primary insurance Annual Deductible amount: $_____.____ Has your deductible been met for the year? Y N I don't know

2. SECONDARY INSURANCE INFORMATION

BCBS MI____BCBS *other state*____ MI Medicaid ____ Medicaid HMO ____ Regular Medicare ____Medicare Advantage Plan ____

Other insurance: _____ Auto_____ None____

Secondary insurance office visit Co-pay amount: (select one) Flat fee Co-pay: $_____._____ or Percentage Co-pay _____%

Secondary insurance Annual Deductible amount: $_____.____ Has your deductible been met for the year? Y N I don't know

3. TERTIARY INSURANCE INFORMATION

BCBS MI____BCBS *other state*____ MI Medicaid ____ Medicaid HMO ____ Regular Medicare ____Medicare Advantage Plan ____

Other insurance: _____ Auto____ None____

** ALL MEDICARE PATIENTS SIGNATURES**

Medicare Signature on file

I request that payment of authorized Medicare benefits be made on my behalf to **Dr. C. Lilly, Dr. Moutsatson, Dr. R. Lilly, K. McConnell, PA-C or C. White PA-C,** for any services furnished to me by **Dr. C. Lilly, Dr. Moutsatson, Dr. R. Lilly, K. McConnell, PA-C or C. White PA-C.** I authorize any holder of medical information about me to release the information to the Centers for Medicare and Medicaid Services (CMS) and its agents in order to determine payable benefits for services rendered.

Signature: _____Date: _____/_____/_____ Medicare ID #_____

Medigap Signature on file

I request that payment of authorized Medigap benefits be made on my behalf to **Dr. C. Lilly, Dr. Moutsatson, Dr. R. Lilly, K. McConnell, PA-C or C. White PA-C,** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents and my Medigap or other insurance policy that I have, any information needed to determine these benefits or the benefits payable for related services.

Signature: _____Date: _____/_____/_____ Medigap Carrier:_____