

Charles Lilly, MD, PC, FAAOS, Michael Moutsatson, DO, PLLC, FAAOS
Ryan Lilly, MD, PLLC, 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 # _____
(reason-insurance verification)

Relationship Status: Single Married Divorced Widowed Partner

Gender Identity _____ Preferred Name *(name to be used when we call you back)* _____

Email Address _____

Patient Phone _____ Home Cell Patient Phone _____ Home Cell

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

Employment status: Full time Part time Unemployed Disabled Retired Student Employer Name _____
(reason-insurance verification)

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

Name & SS# of Responsible Party *(If different than patient, or of patient is a dependent)* _____
(Social Security #) (reason-insurance verification)

Last First Middle Initial

Home Phone: () _____ - _____ Cell Phone: () _____ - _____ Responsible Party's D.O.B. _____

Email Address _____

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

Street/Road/PO Box/Apartment City State Zip

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: ___/___/___

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: ___/___/___