

Pfenninger Medical Procedures Center, P.C.

"We treat people, not just problems."

4800 N. Saginaw Road
Midland, Michigan 48640

Visit our website at: MPCenter.net

Email: info@mpcenter.net



NEW PATIENT INFORMATION

DATE:		REFERRING PHYSICIAN:												
PATIENT DATA	PATIENT'S LEGAL NAME (LAST, FIRST, MIDDLE)				MARITAL STATUS (Circle One)		PREVIOUS NAME		EMAIL ADDRESS					
			M S W D											
	STREET ADDRESS			P.O. BOX		SEX	AGE	DATE OF BIRTH / /		SOCIAL SECURITY NO.				
	CITY		STATE		ZIP CODE		PATIENT'S TELEPHONE NO. Home: Cell:		PATIENT'S WORK TELEPHONE NO.					
	EMPLOYED BY			EMPLOYER'S ADDRESS				PATIENT EMPLOYMENT STATUS - CIRCLE ONE						
	PREVIOUSLY TREATED HERE YES NO			IT IS OKAY TO GIVE MY MEDICAL INFORMATION TO:				Full Time Active Military Self Part Time Retired Not Date: / /						
YEAR														
NEAREST RELATIVE NAME			ADDRESS				TELEPHONE NO.							
EMERGENCY CONTACT	NAME			RELATIONSHIP				TELEPHONE NO.						
	ADDRESS			STREET		CITY		STATE		ZIP CODE				
PHOLLICDER	PERSON RESPONSIBLE FOR BILL			ADDRESS			CITY		STATE		ZIP CODE			
	TELEPHONE NO.		RELATIONSHIP		DATE OF BIRTH / /		EMPLOYER		SOCIAL SECURITY NO.					
	EMPLOYER'S NAME		ADDRESS			STREET		CITY		STATE		TELEPHONE NO. CELL:		
INSURANCE INFORMATION	PRIMARY INSURANCE COMPANY NAME:													
	POLICY HOLDER:													
	SECONDARY INSURANCE COMPANY NAME:													
	POLICY HOLDER:													
	Pneumococcal Vaccine prev received or given			Y N		Influenza immunization ordered/or administered			Y N		Osteoporosis screening		Y N	
	Smoker and received counseling			Y N		Influenza not ordered/given reasons other			Y N		Osteoarthritis screening		Y N	
Non Smoker			Y N		Influenza not ordered/given reason not specified			Y N		e-prescribing		Y N		
					Medication reviewed			Y N		EMR		Y N		
PLEASE BRING INSURANCE CARDS AND DRIVERS LICENSE OR OTHER FORM OF ID WITH YOU TO YOUR APPOINTMENT.														

PRE-AUTHORIZED HEALTH CARE PAYMENT AGREEMENT

We can bill your credit card **AUTOMATICALLY** once the insurance/patient balance is settled.

- Bill my credit card automatically for my account balance after insurance.
- Payment Plan – charge my credit card _____ each month for (4) months.
- I will pay my account in full after I receive my first statement from Medical Procedures Center (approximately 30 days from service date) with cash, check or money order. If my balance is not paid within 45 days from service date Medical Procedures Center will automatically charge my patient balance to my credit card unless I have made prior arrangements.

The Medical Procedures Center PC has my permission to charge my health care fees to my credit card.

Type of Card VISA MasterCard Discover

Card Number _____ Exp. Date ____ / ____ Sec# _____

Name on Card _____

Signature _____

INSURANCE AUTHORIZATION

I, the undersigned, do hereby authorize The Medical Procedures Centers, P.C., to furnish to insurance companies information concerning my illness and treatments and I hereby assign benefits to the physician for all medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or participation agreements and I am responsible to obtain any second opinions or referral slips to enhance billing. A photocopy of this agreement is to be considered as valid as an original. If you are under 18 years of age, please have a parent or guardian sign.

DATE _____ SIGNATURE _____ Relationship _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. In the event that a service is not a covered benefit for Medicare, I agree to pay for services rendered.

DATE _____ SIGNATURE _____ Relationship _____

WE PARTICIPATE WITH BLUE CROSS/BLUE SHIELD OF MICHIGAN, HEALTH PLUS, MEDICARE, DOW, DOW CORNING, CONNECT CARE AND MEDICAID. WE WILL SEND IN YOUR BILL FOR YOU. ALL PATIENTS ARE RESPONSIBLE FOR DEDUCTIBLES, CO-PAYS, AND "NON-COVERED" SERVICES, REGARDLESS OF INSURANCE. THE PATHOLOGY LAB AT THE HOSPITAL WILL BILL YOU OR YOUR INSURANCE FOR ANY SPECIMENS SENT TO THEM FOR EVALUATION.