David Lujan, DO
19900 Ten Mile Road
St. Clair Shores, MI 48080

-FOR OFFICE USE ONLY-

CLINICIAN #______________ ACCOUNT #___________ INSURANCE ___________________________________

PLEASE COMPLETE AND SIGN ALL PAGES WHERE INDICATED. ALL INFORMATION MUST BE COMPLETED.

(PLEASE PRINT)

DATE: ________________________________

***PATIENT* FIRST NAME_______________________ M.I._____ *PATIENT* LAST NAME _____________________________________ SEX M ____ F___**

STREET ADDRESS ____ DATE OF BIRTH _____________

CITY, STATE, ZIP CODE ____

***<u>PATIENT SOCIAL SECURITY NUMBER</u>* ______________________________DRIVER LICENSE# __________________________**

NAME/PHONE NUMBER OF PERSON TO CONTACT IN CASE OF AN EMERGENCY ________________________

____

<u>FOR PATIENTS UNDER 18 YEARS OF AGE</u>:

GUARDIAN NAME _______________________________________GUARDIAN NAME _____________________________________

GUARDIAN ADDRESS ____________________________________GUARDIAN ADDRESS __________________________________

CITY, STATE, ZIP CODE _________________________________ CITY, STATE, ZIP CODE ________________________________

GUARDIAN TELEPHONE # _______________________ ________GUARDIAN TELEPHONE # _______________________

***<u>SOCIAL SECURITY</u> * __________________________________ *<u>SOCIAL SECURITY</u> * ___________________________________**

***<u>DATE OF BIRTH</u>* _____________________________________ *<u>DATE OF BIRTH</u>* ______________________________________**

DRIVERS LICENSE#____________________________________ DRIVERS LICENSE# ___________________________________

<u>PRIMARY INSURANCE:</u>

INSURANCE COMPANY NAME____

I.D. NUMBER ____ GROUP NUMBER _________________________________

POLICY HOLDER NAME__________________________________ RELATIONSHIP __________DATE OF BIRTH _____________

EMPLOYER NAME ____

<u>SECONDARY INSURANCE:</u>

INSURANCE COMPANY NAME____

I.D. NUMBER ____ GROUP NUMBER _________________________________

POLICY HOLDER NAME__________________________________ RELATIONSHIP __________DATE OF BIRTH _____________

EMPLOYER NAME ____

IF THERE ARE INSURANCES IN ADDITION TO THOSE LISTED ABOVE AND IF THERE ARE CHANGES TO THE INSURANCE POLICIES DURING YOUR TREATMENT PLEASE NOTIFTY THE FRONT DESK!!!

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CONSENT TO TREATMENT & DIAGNOSTIC SERVICES

I understand that the services my dependent or I will receive are based on currently accepted practice in the fields of mental health. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

I understand that my records or the records of my dependent are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and federal guidelines, or as allowed by my signature on a release form, with the exceptions written below.

If any service is paid for by an insurance company, either in part or full, I understand that the insurance company or its agents have the right to examine my records at any time. I authorize the examination of my or my dependent's client records by them as they require for reimbursement and verification of services. I also understand that it may be necessary to release information regarding me or my dependent to a Case Manager or insurance verifier from my insurance company in order to process services. I also give my permission to release any information to my insurance company that is required to process insurance claims for services provided my dependent or me.

State of Michigan law requires that certain communicable diseases by reported to the Michigan Department of Health. If it is determined that my dependent or I have such a disease, I consent to disclosure of this to the Michigan Department of Health.

Federal laws and regulations do not protect any information about a crime committed by a client either at a treatment program, or against any person who works for a program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

I understand that fees for services are to be paid at the time of the appointment unless other arrangements have been made. If my insurance company does not cover any fees or any portion of fees for the services my dependent or I have received, I accept responsibility for them. If maximum insurance benefits have been reached, I will be responsible for any fees for services subsequently rendered.

I agree to provide information for the development of the treatment plan to be used. **I will keep scheduled appointments. I accept that I am financially responsible for all scheduled appointments and am aware that any appointment that is missed without my giving 24 hours notice may be billed to me because insurance companies will not pay for missed appointments or late cancellations**. **I understand that I may be billed for these appointments at the usual fee.** If treatment or diagnostic evaluation is terminated by my choice, or because of violation of above rules, I agree to pay all outstanding fees existing at the time of termination.

I understand that it might be necessary to reach me by mail or by telephone during or after my or my dependent's contact for purpose of confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys, and any necessary follow-up.

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DUE TO HIPAA LAWS, IF YOU ARE 18 OR OVER, WE ARE UNABLE TO SPEAK TO ANYONE OTHER THAN YOURSELF REGARDING BILLS OR TREATMENT. IF YOU WANT TO ALLOW US TO SPEAK WITH SOMEONE OTHER THAN YOURSELF PLEASE ASK TO SIGN A RELEASE OF INFORMATION.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services for my dependent or me. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services. I acknowledge that I am aware that the therapist is an independent contractor, self employed, and licensed by the State of Michigan. Further, I have read this Consent and agree with the policies and procedures herein.

____________________________________ ____________________
Signature of Patient (or Parent/Guardian) Date

PERMISSION AND PREFERRED METHOD OF CONTACT

PLEASE ANSWER EACH QUESTION:

THE OFFICE MAY LEAVE A MESSAGE AT HOME ON MY VOICE MAIL OR WITH ANY INDIVIDUAL ANSWERING MY HOME TELEPHONE ( ) YES ( ) NO

THE OFFICE MAY LEAVE A MESSAGE AT WORK IN MY VOICE MAIL. ( ) YES ( ) NO

THE OFFICE MAY MAIL TEST RESULTS OR OFFICE VISIT FOLLOW UPINFORMATION TO MY HOME ADDRESS OR ADDRESS PROVIDED. ( ) YES ( ) NO

PLEASE GIVE US THE BEST PHONE NUMBER TO CONTACT YOU AT:

____________________	____________________	__________________
(HOME MOBILE WORK) **PLEASE CIRCLE ONE**	**(HOME MOBILE WORK)** **PLEASE CIRCLE ONE**	**(HOME MOBILE WORK)** **PLEASE CIRLE ONE**

What is your preferred method for us to contact you? (Circle one) HOME WORK MOBILE

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PAYMENT OF FEES

Every day new insurance companies are forming and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover. You should check with your insurance carrier regarding Outpatient Mental Health benefits so you are aware of your coverage regarding office visits, psychological testing, etc. It is to your benefit to be well informed so to prevent having to pay for a service that may have been covered if you had a referral, prior authorization, etc. We will make every effort to verify your benefits with your insurance company. However, this is not a guarantee of payment. Your insurance company needs to view the actual claim with diagnosis and procedure codes before making any payment decisions. If at any time your insurance company believes they paid us in error and requests reimbursement/recovery from this office you will be responsible for all these fees.

- **You are responsible for all co-pays and deductibles. It is against insurance policy to ignore them.**
- **Fees for services are due at the time of service unless other arrangements have been made.**
- **If maximum insurance benefits have been reached, you will be responsible for any fees for services subsequently rendered.**
- **Educational testing, transcription fees and other miscellaneous fees are not covered by your insurance carrier. These services are not billed to any third party carrier (insurance company) and will be your responsibility.**
- **For those insurance companies requiring authorization and you fail to obtain a referral (when required) or prior authorization (when required), you will be responsible for the service rendered.**
- **If you do not inform us of any insurance changes, you will be responsible for the services rendered.**
- **If you do not inform us of all insurance policies, you will be responsible for the services rendered.**
- **If your insurance plan does not cover services that are rendered, you will be responsible for those services**
- **There is a $25 charge for all returned checks (NSF)**

PRIVATE PAY PATIENTS AND/OR THOSE WITHOUT INSURANCE:

- **If you do not have insurance you are responsible for the fees.**
- **Fees for services are due at time of service unless other arrangements have been made.**

I have read and completed the requested information to the best of my knowledge and ability and understand that I am the financially responsible party for the named patient. The signature is that of the person completing this form. For minor children, the individual bringing the child to this office is considered the financially responsible party.

____ ____________________

Patient/Guardian Signature **Relationship** **Date**

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IF YOU ARE REQUESTING THAT WE BILL YOUR INSURANCE(S) PLEASE COMPLETE AND SIGN BELOW:

ASSIGNMENT AND RELEASE FOR PRIMARY INSURANCE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH ___________________ AND ASSIGN DIRECTLY TO DR. ___________________________________ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

ASSIGNMENT AND RELEASE FOR SECONDARY INSURANCE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH ___________________ AND ASSIGN DIRECTLY TO DR. ___________________________________ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

____ ____ ___________
SUBSCRIBER/CUSTODIAL PARENT/GUARDIAN RELATIONSHIP DATE

Revised 12/28/2016