COMPLETE FAMILY CARE

43956 MOUND ROAD
STERLING HEIGHTS, MICHIGAN 48314

Patient Contact and Insurance Subscriber Information

Patient Information

Last Name	First Name	Middle Name

Street Address	City	State	Zip

Home Phone	Cell Phone	Email Address

Date of Birth	Age	Social Security #	Sex

Emergency Contact	Phone Number	Relationship

Insurance Subscriber Information (if different from above)

Last Name	First Name	Middle Name

Street Address	City	State	Zip

Date of Birth	Age	Social Security #	Sex

Subscriber's Employer	Employer's Phone Number

Assignment of benefits – I authorize payment of medical benefits to, AlternaCare DBA Complete Family Care for services rendered to my child or myself. I understand that to the extent permitted by law, I am responsible for any costs not covered under my insurance policy. **The costs not covered under my plan, such as copays, are expected to be paid at the time of service or a billing fee will be applied.** I authorize the release of any medical information, including any information related to AIDs, AIDs related complex or HIV and any information regarding substance abuse treatment to any third party responsible for paying all or part of my child's or my own medical bill. I agree no one has promised or guaranteed any results of my child's or my own medical care. I agree that nothing in the form prevents the doctor or staff from terminating care of my child or me, if I am given notice and chance to obtain medical services elsewhere. This authorization shall remain in effect, unless written and signed cancellation is given.

Patient/Legal Guardian Signature	Date	Witness Signature	Date

Steven Margolis, MD
Christina Munn, PA-C
Bethany Morrell, PA-C
Brittany Sharp, FNP-BC

43956 Mound Rd.
Sterling Heights, MI 48314
(586) 838-2464
Fax (586) 221-4614

Complete Family Care

Acknowledgment of Receipt of Notice of HIPAA Privacy Practices

Today's Date:____________________

I have reviewed a copy of the HIPAA privacy notice:

____

Patient_Name_(please_print)

____

Signature_of_Patient/Legal_Guardian

Please list below the name(s) and relationship to only the person(s) in which we, Complete Family Care, are authorized to release your protected health information to.

Name_	Relationship_
Name_	Relationship_
Name_	Relationship_
Name_	Relationship_