PATIENT INFORMATION SHEET

Please present all insurance cards and valid picture ID

Patient Name	Birthdate	SSN: *(for internal use only)* Marital Status *if listed as unknown, please change*	Sex
Patient Address		Join ***MyChart***—our patient portal—ask about how to get activation code	
Preferred Phone	**Alternate Phone:**		*Work Phone:*
Preferred Contact Method: (circle one) *Phone Mail Portal* Driver's License #	Race: *(if blank, circle one)* American Indian/Alaska Native Hispanic Other Pacific Islander Asian More than 1 Race White Black/African American Native Hawaiian Refuse to Report		Ethnicity: *(circle one)* *Hispanic or Latino* *Not Hispanic or Latino* *Refuse to Report*

You may wish to authorize release of your health information to family members or others as you designate. We require the use of a PIN number. You have the option of selecting a PIN number or using the one assigned by us. You may provide this number to any individual who may have access to your privileged information. (*optional*) **PIN NUMBER REQUESTED (4 DIGITS**

Usual Physician	Referring Physician	Preferred Language *(if other than English)*
Guarantor Name	Guarantor Address	PCMH –Ask us about our PCMH Brochure!
Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone Numbers (*home, cell, work)*
Primary Insurance Name	Secondary Insurance Name	Tertiary Insurance Name
Primary Insured Date of Birth	Secondary Insured Date of Birth	**IS THIS RELATED TO WORK OR AUTO ACCIDENT?** **YES NO** **IF YES, YOU MUST PROVIDE THE DATE OF ACCIDENT AND ALL BILLING INFORMATION**

Release of Information and Authorization to Pay Benefits to Physician:

1. I authorize Karu Medical Associates to release to my insurance company, including Medicare, Medicaid, Medigap/Supplemental benefit insurances, as applicable, any information regarding my treatment and diagnosis of my condition necessary to obtain payment for services rendered to me.
2. I authorize and request such payments be made directly to KARU MEDICAL ASSOCIATES for any amounts due for medical services.
3. **Medicare Patients**: I authorize release of medical and other information necessary to process claims to Centers for Medicare and Medicaid Services (CMS) and it's agents needed to determine these benefits payable for related services.

. I request payment of authorized Medicare benefits be made on my behalf to Karu Medical Associates for any services furnished to me.

Electronic Exchange of Information I consent to Electronic Exchange of Information through Health Information Exchange (HIE), including networks that participate in statewide exchange services, such as but not limited to, Michigan Health Information Network (MiHIN), as well as healthcare providers, health systems, laboratories, pharmacies, health plans, immunization registries, ePrescribing data and formulary information. I understand that information disclosed through electronic exchange may be redisclosed by recipients as permitted by law but will remain protected under applicable federal and Michigan laws.

Authorization to Communicate via Cell Phone (or leave voicemail message on landline) I authorize Karu Medical Associates to communicate with me via mobile phone or landline numbers listed above for the purposes as follows, including, but not limited to, phone calls, text messages (SMS/MMS), and voicemail messages related to appointments, office operations, patient care updates, and/or billing.

Acknowledgement of Notice of Privacy Practices (HIPAA) The undersigned patient or legally authorized representative of patient acknowledges that he or she received a copy (or was offered) of the Karu Medical Associates Notice of Privacy Practices on the date indicated below.

Signed (patient or authorized representative) **Date**

Karu Medical Associates does not discriminate on the basis of race, ethnicity, religion, age, gender, gender identity, or marital status