CAPSTONE
FAMILY PRACTICE

Thank you for considering Capstone Family Practice, PLC., in Eaton Rapids, as your potential future medical home. The Capstone Provider team includes Dr. Ivan Morris, D.O., Julie Teceno, FNP-C and Pamela Becker, NP-C. Our board-certified family practice nurse practitioners, Julie Teceno and Pamela Becker, are currently accepting new patients at Capstone Family Practice. At this time, Dr. Morris is not scheduling patients at this location, as he also owns a practice in East Lansing.

When calling to schedule an appointment with our office, please state if you have previously been an established patient. If you are in need of medication prior to an appointment, please contact the office where you are currently a patient to receive continued care. We are not able to refill medications until you have had an appointment and have established care at Capstone Family Practice.

Capstone providers are working closely with a credentialing organization to obtain contracts with numerous health insurance carriers. Please advise us of your insurance when you call for an appointment. Unfortunately, there may be a delay with certain insurances. We are happy to discuss a cash payment option with you if your insurance carrier is still pending approval with us. It is important to note, that we are not currently able to accept any Medicaid insurance plans as primary insurances. Please refer to the enclosed document regarding Medicaid as a secondary insurance with our office.

Capstone Family Practice, PLC

Currently we are not an approved provider for any Medicaid plans in the state of Michigan. Therefore, according to Michigan law, we are not able to see any patients who have Medicaid as primary insurance. However, we are permitted to see patients who have Medicaid as a secondary insurance. We cannot bill Medicaid for services provided at Capstone Family Practice, PLC. Patients will be responsible for their copayment per their primary insurance.

Please be aware that there may be difficulties in the future due to these laws: for example, you lose your primary insurance and have only Medicaid, we are not able to see you for any appointments per the state of Michigan. This also includes cash pay appointments or a no-charge appointment. Medication copays, home care supply costs, referrals, and certain prior authorizations are all situations that have potential to impact your future as a healthcare consumer.

We are happy that you have chosen Capstone Family Practice, PLC., to provide your healthcare needs and our goal is to avoid any difficulties you may experience in relation to the above situations.

We ask that you acknowledge the above information with a signature, confirming that you accept responsibility for copayments at time of service.

Name: **Date:**

Capstone Family Practice, PLC

Patient Authorization for Personal Representative
Please print all information, then sign and date form at bottom.

Patient Name: _____ _____ Social Security Number: _____

Date of Birth: _____/_____/_____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1.) _____
Name of Personal Representative Phone

_____
Address City State Zip

2.) _____
Name of Personal Representative Phone
Address City State Zip

- Description of information to be disclosed: I authorize the practice to disclose all my protected health information to my designated personal representative.
- Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity authorized to do so by court order or law.
- Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Attn: Office Manager
Capstone Family Practice
2487 S. Michigan Rd
Eaton Rapids, MI 48827

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

X _____
Patent Date

Copies of signed authorizations are available upon request.

Capstone Family Practice PATIENT HISTORY FORM

Name:_____ Date of Birth:_____ Date:_____

Social History

Marital Status: Single Married Divorced Widow Other **Occupation:**_____ Retired From:_____

Do you have a Living Will/Durable Power of Attorney? Yes No ☐ I desire more information

Are you currently using or participating in the following:

Alcohol	*Yes*	*No*	Type:		How Often/Amount:	
Caffeine (Coffee, tea, soda)	*Yes*	*No*	Type:		How Often/Amount:	
Illicit/Recreational Drugs	*Yes*	*No*	Type:		How Often/Amount:	
Tobacco	*Yes*	*No*	Type:		How Often/Amount:	
Never Smoked	*Yes*	*No*	Quit:	(Year)	E Cigaretttes/Vapes:	
Exercise	*Yes*	*No*	Type:		How Often/Amount:	
Diet--Well balanced or Poor			Any Dietary Restrictions:			
History of Abuse	*Yes*	*No*	Type:		Currently Abused: Yes or No	
Military History	*Yes*	*No*	When:		Where:	
Active in Spiritual Interests	*Yes*	*No*	(Church-religious)			
Sexually Active	*Yes*	*No*				

Personal Medical History (please check all that apply)

___Anemia	___Epilepsy/Seizure	___Migraines
___Asthma	___Heart Disease	___Osteoporosis
___Arthritis	___ Heart Failure-Congestive	___STD History
___Bleeding Disorder	___ High Cholesterol	___Stroke
___Cancer	___High Blood Pressure	___Thyroid Disease
___COPD/Emphysema	___Kidney Disease	Other_____
___Depression/Anxiety	___Liver Disease	Other_____

Any problems or concerns with:

Fatigue, change in weight or energy level? Yes/No
Easy bruising, bleeding or anemia? Yes/No
Changes in vision or hearing? Allergies/congestion? Yes/No
Shortness of breath, cough, wheezing, lung issues? Yes/No
Chest pain, palpitations, angina, heart problems? Yes/No
Stomach upset, heartburn, change in bowel habits? Yes/No
Difficulty emptying bladder, urinary frequency? Yes/No
Aches or pain in arms, legs, trunk, neck? Yes/No
Changes in your skin, irregular spots? Yes/No
Dizziness, headaches, numbness or tingling? Yes/No
Mood swings, depression, anxiety, anger, insomnia? Yes/No
Problems with sexual functioning, pain with sex, loss of interest? Yes/No
Problems with snoring or sleep apnea? Yes/No
Latex or Iodine allergy? Yes/No

Surgeries or Hospitalizations

Date	Type

Medical procedures in the past? Cardiac Stress Test Cardiac Cath EGD Colonoscopy Mammogram

Immunizations: Date of last Tetanus:_____ Pneumococcal vaccine:_____

If Applicable:

Last Menstrual period:_____ Number of Pregnancies_____ Number of Live Births_____

Name:_____ Date of Birth:_____Date:_____

Please list in order your preference to be contacted:
(List in order of 1, 2, 3)

_____ Home Phone Number: _____
_____ Cell Number: _____
_____ Text: _____

Current Medication, Vitamins and over the counter supplements List

Medication	Dose Amount	How Often Taken

Medication Allergies: Yes or No (if yes, list below)	Reaction

Family History

Please list below any of the following major illnesses in your family history: Diabetes, Heart Disease, Cancer, Bleeding Disorder, Stroke, Hypertension, Etc.

Relative	Medical Illness	Alive/Age at Death
Father		
Mother		
Brother		
Sister		
Maternal Grandfather		
Maternal Grandmother		
Paternal Grandfather		
Paternal Grandmother		
Other		

Please list below any changes in surgeries, hospitalizations, new medical problems or medications since your last visit: _____

_____

_____

_____

Capstone Family Practice

2487 S. Michigan Rd, Eaton Rapids, MI 48827
Phone: 517-836-2178 Fax: 517-836-2182

PATIENT DEMOGRAPHICS

Patient Name:		*Date of Birth:*	
Address:	*City:*	*State:*	Zip Code:
Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced	*Sex:*	*Age:*	
Social Security#:	*Preferred Phone#:*	*Secondary Phone#:*	
Email Address:		*Primary Language:*	
Please circle the first and second choice of contact: 1 or 2 Phone - Number:			
1 or 2 Text - Cell Number:			

Race: (Please check appropriate choice)

( ) White/Caucasian ( ) Asian ( ) American Indian/Alaska Native

( ) Black/African American ( ) Native Hawaiian ( ) Multi-racial ( ) Decline to Report

Ethinicity: (Please check appropriate choice)

( ) Hispanic/Latin American ( ) Non-Hispanic/Latin American ( ) Decline to Report

Responsible Party Name:	*Date of Birth:*		*Sex:*
Address: (If different than patient)	*City:*	*State:*	*Zip Code:*
Preferred Phone#:	*Secondary Phone#:*		

Emergency Contact Name: *(Outside of the household)*

Prefererred Phone#:	*Secondary Phone#:*	*Relationship:*

HEALTH INSURANCE INFORMATION

Primary Insurance	*Secondary Insurance*
Carrier Name:	Carrier Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy ID:	Policy ID:
Group #:	Group #
Co-Pay:	Co-Pay:

Capstone Family Practice

Patient Financial Policy

To our Patients,

We are committed to providing excellent care for you and your family. Therefore, the intent of this document is to inform you of your financial responsibility and help you understand medical services, coverage, eligibility and medical insurances. We are not eligible to accept Medicaid as either primary or secondary insurance. Patients who have Medicaid as secondary will be responsible for their copay at time of service.

For your understanding:

- Knowing and understanding your insurance policy, coverage and eligibility is the patient's
- responsibility
- Medical treatment is based on medical guidelines, not insurance coverage
- All services are not covered by all insurance companies/third party payers, as each policy has its
- own particular benefits regarding covered services, or amount of coverage
- Your insurance company determines the actual benefits after a claim is received

Financial Responsibilities:

- We accept most insurance companies, but you must verify that our providers are in network so that you can receive the highest benefits possible
- Patients must provide accurate insurance information and ID's (address) upon arrival. Any changes must be reported to our office promptly. Payment will be required in full for incorrect information
- Patients are responsible for full payment of Deductibles, Co-Insurances, Co-Payments, services deemed as "not a benefit" or "non-covered" services
- Patients are responsible for payment of all outstanding balances at the time of service. Copays are collected upon arrival. If payment is not made, you will be asked to reschedule.
- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.
- Regardless of divorce settlements, the patient being seen is responsible for charges incurred.
- Our Medicare patients may be asked to sign an Advance Beneficiary Notice (ABN) form as required by Medicare for certain services
- Self-Pay Patients (no insurance) are required to pay $150 at check-in and any balance due within 30 days
- We require a 4 hour notice for cancelling appointments. If notice is not received, we may charge a $25 fee for standard appointments and $75 for extensive appointments, such as physical exams, timely procedures, and new patient visits.
- A fee will be charged for Medical Records requests and payment must be made prior to release
- All claim information for an Auto Accident must be provided before treatment
- We do not participate with Workers' Compensation cases
- We reserve the right to turn any account over 90 days past due to a collection agency if it is deemed in default or noncompliance with this policy
- By signing this document, the Patient or Patient's Representative authorizes Capstone Family Practice and its' third party billing and/or collection services providers to use any and all information provided by the Patient or Representative for contact, included cell phone, if required.

I hereby acknowledge that I have reviewed this policy and agree to the terms/conditions of the policy.

Minor (Child's) Name: _____ DOB: ____/____/_____Date: ____/_____/____

Patient or Guarantor: _____DOB:____/____/_____Date: _____/_____/___

Capstone Family Practice, PLC

Patient Acknowledgement:

Notice of Privacy Practices

&

Information about Advanced Directives

&

Medical Home

I acknowledge that I have been provided a copy of or access to:

- **Notice of Privacy Practices**
- **Information about Advance Directives**
- **Medical Home**

Patient Name:_____ **Patient DOB:**_____/_____/_____

Patient Signature:_____ **Date:**____/_____/_____

Guardian Name:_____

Guardian Signature:_____

The patient named above has been offered these materials. However, patient refused to sign this acknowledgement form. A good faith has been made to offer these materials and obtain a signature of receipt.

Name of Staff Member: _____ **Date:** _____

Signature of Staff Member: _____

****** Forms and brochures are available at www.capstoneeatonrapids.com ******