

Step 5

Center for Contemporary Medicine Patient Information 220 Collingwood, Suite. 130, Ann Arbor, MI 48103

Last Name _____		First Name _____		M.I. _____	
Date of Birth _____		Social Security Number _____		Sex: Male Female	
Marital Status: M S D		Spouse's Full Name _____			
Address _____		City _____		State _____	
Zip _____		Telephone # (____) _____		Email: _____	
Fax Number (____) _____		Calling Card/800 Number _____			
Employer _____		Work Number (____) _____			
Work Address _____		Occupation _____			
If a minor, Name of Parent/Guardian _____					
Emergency Contact _____		Emergency Telephone Number (____) _____			
Primary Care Physician _____		Telephone Number (____) _____			
Address _____					
Pharmacy _____		Telephone Number (____) _____			
Address _____					
Referring Physician _____		Telephone (____) _____			

Authorization, Assignment and Release: I acknowledge that I am financially responsible for all services. I **Also Realize That All Practitioners Providing Services At the Center for Contemporary Medicine Are Not Contracted with Medicare or Any Other Health Plans.** The Center for Contemporary Medicine will provide the necessary information for the patient to file their own claims.

I also authorize the physician to release any information required in my care or in the processing of any claims. I further consent to the sharing of medical information concerning my health among the employed and contracted practitioners and staff at CCM.

I further acknowledge financial responsibility for any charges for services rendered and that payment is expected at the time of service. If I am unable to keep a scheduled appointment, I agree to notify the Center for Contemporary at least 24 hours in advance. If I fail to provide 24 hours' notice of cancellation, I agree to pay a fee for the appointment I missed.

(Exceptions: bona fide emergencies and acts of God)

Signature _____ Date _____

Signature of Guardian _____ (if required) Date _____