Grand Valley
Medical Specialists, P.L.C.

Preventive Health Reminder:
Preferred Method of Communication: ❑ Postal Mail ❑ Phone ❑ Web Mail

In order to communicate with us via secure e-mail, please give us your email address and we will extend an invitation to you to activate a secure e-mail account

Patient Information

Patient Name: Last	First	MI	Phone ( ) / Cell ( )
Address			Birth Date / SS#
City	State	Zip Code	Gender ❑ Male ❑ Female / ❑ Single ❑ Married ❑ Widowed ❑ Divorced
Emergency Contact Last	First	MI	Relationship / Phone ( ) / Cell ( )
Patient Employer			Occupation / Phone ( )
Address			
City		State	Zip Code
Spouse Name Last	First	MI	Phone ( ) / Cell ( )
Address			Birthdate
City		State	Zip Code
Spouse Employer			Occupation / Phone ( )
Address			
City		State	Zip Code
Language	Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to Report		
Race ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian ❑ White ❑ Black or African American			

Medicare Part B "One Time Authorization Agreement" statement to permit payment of Medicare Benefits to Provider, Physicians, and Patients.

"I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its Agents any information needed to determine these benefits for related services."

X Payment to Provider

X _____ _____
Patients Signature Provider

Authorization for the release of Medical Information and Statement of Financial Responsibility.

"I hereby authorize the release of any medical information necessary to process claim(s) for the payment of benefits either to myself or Grand Valley Medical Specialists, PLC."

"I further agree to assume financial responsibility for these services and will pay to Grand Valley Medical Specialists, PLC., to the full extent legally due them, any amounts not paid directly to them by Medicare, Blue Shield, or other insurance company."

X _____
Patient or Responsible Party Signature

Acknowledgement of Receipt

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she received a copy of the Grand Valley Medical Specialists, PLC, Notice of Privacy Policies on the date indicated below.

Date: _____ Signature _____ Name of Patient _____

If this acknowledgment is not signed by the patient, please print the information set forth below:

Name of person signing _____ Relationship to Patient _____