Mary Lee M.D. P.C.

5799 West Maple Road
Ste. 163
West Bloomfield, MI 48322

Patient Registration Form

Patient Information

Name:______________________ Social Security #:______________ Birthdate:______________

Address/City/State/Zip:______________________________________ Male:___ Female:___

Home Phone:______________ Daytime:______________ Cell Phone:______________

Employer:______________ Occupation:______________ Marital Status: S_M_D_W_

Spouse's Name:______________ SS#:______________ Birthdate:______________

Pharmacy Name/City/Phone/Fax: ______________________________________

For A Minor: Financially Responsible Person

Name:______________________ SS#:______________ Male:_______ Female:_______

Address/City/State/Zip: (if different from patients)______________________________

Home Phone:______________ Daytime:______________ Cell Phone:______________

Relationship to Patient:______________________________________

Emergency Contact

Name/Address:______________________________________ Relationship:______________

Home Phone:______________ Daytime:______________ Cell Phone:______________

Insurance Information

Please provide your insurance card(s) to be copied. If your insurance information is not received within 24 hours, you will be billed for the service rendered.

Please mark all that apply:

This Visit is related to an Auto Accident______________ If Yes, DATE OF THE INJURY?______________
This visit is related to an injury at work______________ If Yes, DATE OF THE INJURY?______________
The patient does not have insurance______________ Adjuster's Name/Phone #______________

1st Insurance Name/Address:______________________________ Effective Date:______________

Policy Holder Name:______________________ SS#:______________ Birthdate:______________

2nd Insurance Name/Address:______________________________ Effective Date:______________

Policy Holder Name:______________________ SS#:______________ Birthdate:______________

I authorize the release of medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to me. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any charges incurred that are not covered by my insurance company. I have read this information and I understand it. I understand that I am responsible for my insurance co-pay at the time of my visit.

Signature: ______________________________________ Date: ______________

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Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of <u>MOST</u> of you prescriptions directly to your pharmacy of your choice and it will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescription to mail order pharmacies.

To implement this new program we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, of you have a mail order benefit program, please proved that information by selecting the appropriate box below and writing in your mail order pharmacy member/ID number.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, ph, fax) as any information provided will be helpful.

Any Drug ALLERGIES? ______________________________

Patient name: ____________________ **Date of Birth:** ______________

Main Pharmacy:

*Name (i.e. CVS, Rite Aid, etc) : ______________________________

Street Name and City: ______________________________

Phone: ____________________ Fax: ____________________

Additional Pharmacies (you would like to keep on file):

*Name (i.e. CVS, Rite Aid, etc) : ______________________________

Street Name and City: ______________________________

Phone: ____________________ Fax: ____________________

*Name (i.e. CVS, Rite Aid, etc) : ______________________________

Street Name and City: ______________________________

Phone: ____________________ Fax: ____________________

Mail Order Pharmacy: (circle one) **ID #:** ____________________

- Medco Caremark Express Scripts Pharmacare CatalystRx AdvantageRx Other: ____________________

Mary Lee MD, P.C.

Authorization and Responsibility Agreement

We invite you to discuss any questions regarding our services and policies. The best health services are based on a mutual understanding between provider and patient. Your insurance policy is a contract between you and your insurance company. We are not involved in that contract. Our relationship is with you, not your insurance company.

I hereby authorize my insurance company to pay directly to Mary Lee MD, P.C. any professional or medical expense benefits for services rendered. If my insurance company does not pay my balance within 30 days, I will be responsible for contacting my carrier to inquire about the delay. I understand that ultimately it is my responsibility for payments of services rendered.

I authorize Mary Lee MD, P.C. to release any information pertinent to my care to any insurance company, adjuster, and attorney involved; and hereby release Mary Lee MD, P.C. from any consequence thereof. A photocopy of this agreement shall be considered as effective and valid as the original.

I understand it is my responsibility to inform Mary Lee MD, P.C. of any changes in my medical insurance status.

______________________________ ____________________

(Signature of patient or parent/guardian) (Date)

If responsible party signs, please fill out the following:

______________________________ ____________________ _______________

(Print Name) (Relationship to Patient) (Phone Number)

Financial Responsibility

Our office policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made, or current and complete insurance information is submitted.

I understand that I am responsible to pay for services rendered, including costs of collection in the event of default. I further understand that if a payment becomes 30 days past due it is considered delinquent. Delinquent accounts will be charged a monthly statement fee of $10.00. After two billing statements, accounts will be turned over to an outside collection agency. Accounts that are sent to collections will incur an administration fee of $50.00. Returned check fees will be assessed a $35.00 fee.

______________________________ ____________________

(Signature of Patient or Parent/Guardian) (Date)

If responsible party signs, please fill out the following:

______________________________ ____________________ _______________

(Print Name) (Relationship to Patient) (Phone Number)

**If the patient is under 18 years of age, a parent or guardian signature is needed.

Notice Of Use And Disclosure Of Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFOMRATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for purpose of treatment, payment, or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurance company, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at anytime in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefit programs, employers (in case of work-related illness or injury), courts, and administrative tribunals.

We will contact and/or send mail to you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. You may want a friend or family member to discuss care with a physician or staff member, take messages, and pick up prescriptions, or other medically related communications.

- Please indicate if there is a friend or family member to whom we are allowed to release medical information to:

  Name: ______________________________ Phone: ____________________

You may also identify a friend or family member to whom we are specifically restricted from releasing medical information:

- Please indicate if you want medical information restricted from:

  Name: ______________________________ Phone: ____________________

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new provisions effected for all protected health information that was maintain. We will provide you with a revised version by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

For more information, please contact us, Mary Lee M.D. P.C, at (248) 419-5111 on 5799 W. Maple Road Ste. 163, West Bloomfield, MI 48322.

This Notice is effective: ____ /_____/20____

The Undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

______________________________ ______________________________

(Signature) (Print Name)

Mary Lee M.D. P.C.
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EHR-Patient Portal Consent Form

Printed name:______________________________

Patient address:______________________________

Patient e-mail address:______________________________

1. RISK OF USING E-MAIL

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper an electronic files.

b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.

c. E-mail senders can easily misaddress an email.

d. E-mail is easier to falsify than handwritten or signed documents.

e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into computer systems.

i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. **Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.**

d. If the patient's e-mail requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. ****The patient should not use e-mail for communication regarding sensitive medical information**, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

f. The patient is responsible for informing Provider of any types of information the patient does not want to besent by e-mail, in addition to those set out in 2(c) above.

g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

i. ****It is the patient's responsibility to follow up and/or schedule an appointment if warranted.**

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform Provider of changes in his/her email address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
f. Inform Provider that the patient received an e-mail from Provider.
g. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to Provider.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature: ______________________
Date:______________________

Witness signature: ______________________
Date: ______________________