Karle Medical Group, P.C.
455 Barclay Circle, Suite D
Rochester Hills, MI 48307
T: 248-852-9596 | F: 248-852-9596

Christine L. Karle, D.O
Rabia A. Cacco, M.D.
Bridget C. Karle, M.D.
Tracey R. Ticcony, N.P.C.
Kristie Burkland, N.P.C.
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PCMH Patient-Provider Partnership Agreement

Made Between Karle Medical Group and You (Our Patient)…

As a Patient-Centered Medical Home, we are committed to your life-long health and well-being. We believe that to achieve this goal there must be a partnership between the patient and your medical provider (physician or nurse practitioner). Below are just a few of the highlights of what you can expect from your relationship with Karle Medical Group. We commit to a large number of other ongoing activities and technologies to support our Patient Centered Medical Home. We hope that you will take the opportunity to ensure your health and well-being as vigorously as we will.

We agree to work together to…

- Care for short term illnesses and manage long-term chronic diseases
- Achieve and maintain your health over your lifetime

You agree to work together to…

- Be open and honest in providing your doctor with your health-related information
- Agree to keep scheduled appointments at our office as well as with any specialists
- Follow the medical care plan that is agreed upon at your office visit as best you can
- Participate in developing an action plan to self-manage a chronic condition (such as diabetes, asthma, etc.) if applicable
- Take steps to achieve a healthy lifestyle and get preventive services
- Agree to ask questions if you do not understand any portion of your health care
- Notify us if your insurance, prescription coverage or financial situation changes

Your Medical Provider agrees to work together to…

- Respect your privacy and keep the information confidential
- Offer appropriate medical advice and information based on current recommendations
- Engage in an open and honest discussion of all treatment options
- Seek opinions from high quality specialists, when needed, for your care
- Help to keep your healthcare affordable
- Ensure access to care after hours (by answering service, phone, urgent care or ER) if needed

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Patient Demographic Information

Your Karle Medical Group Doctor: _____ Date: _____

Patient Information

Last Name _____First Name _____MI_____ Soc. Security #_____

Street Address_____ Suite/Apt # _____

City _____State _____ Zip-Code_____

Date of Birth _____ Sex _____ Marital Status_____

Cellular Phone _____ Work Phone _____Home Phone_____

May we leave messages? On (Y/N) Cell Phone _____Work Phone _____ Home Phone_____

Email:_____

Emergency Contact_____ Emergency Contact's Phone #_____

Preferred Language* _____Race/Ethnicity*_____ (If you decline to declare, write "Decline".)

Preferred Pharmacy Name and Cross Streets: _____ Pharmacy Phone_____

Responsible Party (Subscriber/Insurance Contract Holder) – the **4 bolded** items are required if you are not the insurance subscriber

Relationship between the patient listed above and the primary insurance holder? _____

RP Last Name _____ **RP First Name** _____MI____ Soc. Security #_____

Street Address_____ Suite/Apt # _____

City _____State _____ Zip-Code_____

RP Date of Birth _____ Sex _____ Marital Status_____

Home Phone _____ Work Phone _____Cell Phone_____

Insurance Information

Insurance Company_____ Subscriber Name_____

Insurance Contract Number _____Group Number _____Effective Date_____

Financial Responsibility Statement

This information is accurate and true to the best of my knowledge. I acknowledge and accept responsibility for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. I understand that co-payment, deductibles, and patient balances are due at the time of service. If I do not pay at the time of service I will be charged a $5.00 account maintenance fee. I further understand that if a payment becomes 120 days past due, delinquency at the lesser of the annual rate of 26%, or the maximum allowable rate will be due on delinquent amounts from the date the payment was due. Any debt that is over 365 days overdue will be charged a 50% collection agency fee which will be required to be paid by the owing patient.

Signature:_____ Date:_____

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HIPAA Compliant Medical Information Sharing Authorization Form

Protected Health Information Sharing Designation

I, _____, grant permission for the person whose name is printed below to receive information regarding my medical care from the Karle Medical Group without additional authorization, and outside of my presence. By providing a name below and signing this form, I understand that the individual named below will have access to my medical records without additional consent unless and until consent is explicitly revoked in writing.
If no name is indicated above, then no layperson will have access to any information contained in my health record from Karle Medical Group.

Spouse:_____

Relative:_____

Caregiver:_____

Other Relationship:_____

Protected Health Information Messages

I **authorize** _____ /**prohibit** _____ the communication of detailed health information by the staff of Karle Medical Group in the form of voice-mail or answering-machine messages at my contact telephone number.

_____
Signed Date

_____
Print Name of Signatory

_____
Witnessed Date

_____

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Print Name of Witness

Patient Missed Appointment Policy

We at Karle Medical Group appreciate you greatly as our patient and strive to accomplish wonderful results and the optimum of health for you as well as the other members of our patient community. We believe we provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something everyone in our office takes quite seriously. Furthermore, we embrace that commitment equally for all of our patients.

Similarly, your commitment to the healthcare process is required. We require your commitment to maintain the highest standards of healthcare on your behalf and on behalf of all of Karle Medical Group's patients. Appointments with our doctors are our primary means to provide our patients healthcare. An appointment that is not utilized because it is not cancelled or rescheduled is a missed opportunity to provide care for another patient. For optimal care for all of our patients, it is imperative that appointments are kept when scheduled or cancelled in a timely manner. Therefore, in order to reinforce a practice of appointment cancellation and/or rescheduling, our practice has instituted a Missed Appointment Policy in which we must enlist your participation. We hope that this policy is understood by our patients as a means to ensure that every appointment is treated as important and valuable.

1) We expect you to keep all your appointments. Write down the time of your visits. With the exception of serious emergencies it is expected that you keep all your appointments.
2) If you need to re-schedule an appointment we require a minimum **24 hours notice**. In such a case, please call our office at (248) 852-9596 and arrange for a make-up appointment with one of our Front Desk Receptionists. The appointment should be rescheduled for the same week, preferably the very next day if possible.
3) In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a fee.

    - In the case of a 15 minute scheduled appointment time or Pre-Phyisical, the fee will be $50.00.
    - In the case of a Complete Physical or other 30 minute scheduled appointment, the fee will be $75.00.

4) In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care due to non-compliance with our treatment plans.

I understand and agree to adhere to the Karle Medical Group appointment policy.

_____

Patient Signature Date

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Patient Name (Print Please)

Insurance and Authorization Information

I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examination that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations of code 42 of federal regulations, part 2 if any; psychological services, if any; social services records, if any, to my insurance company(s) for the purpose of payment of bills to my health care provider for continuity of care. I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by insurance.

I understand that if any employee or physician of Karle Medical Group, P.C., sustain a subcutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for the Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I hereby certify that the contents of this form are understood by me. Paragraphs or lines that I choose not to pertain to me, if any, were stricken and initialed by me, before I signed:

I attest that the information that I have provided on this form is complete to the best of my knowledge.

Patient Name (Please Print):_____

Patient Signature:_____

Responsible Party Name (where appropriate):_____

Responsible Party Signature:_____

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Agreement of Responsibility:

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of services. I understand that I am responsible for charges not covered by my insurance company.

Consent to Treat:
I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in her/his judgement.

Release of Information / Assignment of Benefits:
I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. I hereby authorize Karle Medical Group, P.C., its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its management functions as they deem necessary.

Medicare Authorization
I request payment of authorized Medicare benefits be made on my behalf to Karle Medical Group, P.C., for any services furnished to me by that physician/supplier. I authorize the holder of the medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization
A Medigap Authorization is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medical Supplemental policy is a health insurance policy or other health plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient / legal guardian.

Name:_____ Date:_____

Signature (Patient / Legal Guardian):_____

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HIPAA Form E Notice and Acknowledgement

Acknowledgment

I acknowledge that I have reviewed the Karle Medical Group Notice of Privacy Practices or that I have waived the right to read the Karle Medical Group's Notice of Privacy Practices document.

_____

Signed Date

_____

Print Name of Signatory

_____

If Signatory Not Patient, Please Indicate Relationship to Patient

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Current Medication List

Name:	**Birthdate:**
Phone Number:	**Doctor at this office:**

Allergic To/Describe Reaction:	**Allergic To/Describe Reaction:**

List all prescription <u>and</u> over-the-counter (non-prescription) **medications** such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort) Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)

Date Started	**Name of Medication**	**Dosage and Directions: How often? How many? Number Prescribed?**	**Need Refill? (Mark X)**	**Reason for taking**

Indicate any medications that **<u>require refills today</u>** with an "X"

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Patient Portal Form

In order to provide you with the best possible care that we are able, we ask that you provide Karle Medical Group with your email so that we can send you a registration invitation for our patient portal. Why should you consider the patient portal?

WHAT IS IT?

The patient portal is an online tool that provides anywhere, anytime access to your personal health records, and enables you to take a proactive role in managing your care.

WHY SHOULD PATIENTS USE IT?

With the portal patients can:

- Review their medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results, read medical notes from their doctor
- Update health information (allergies, medications, conditions, etc.)
- Request Rx refills
- Request or change appointments
- Fill out and submit forms prior to appointments
- View and pay bills

Name (Print Legibly): _____ Date of Birth: _____

Email Address: _____

(Initial)_____ I would like the patient portal invitation sent to me.

(Initial)_____ I would **NOT** like the patient portal invitation sent to me.

(Initial)_____ I have already signed up with the patient portal.

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Patient Specialist List

In order to provide you with the best possible care that we are able, we ask that you provide Karle Medical Group with a complete a list of your other doctors as available. If you can provide phone numbers for the doctor's office we would be appreciative.

Printed Patient Name: _____ Date of Birth: _____

Doctor Specialty	Doctor Name	Contact Information
Allergist		
Cardiologist		
Colorectal Surgeon		
Dermatologist		
Endocrinologist		
Geriatric Specialist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Obstetrician		
Ophthalmologist		
Orthopedic Surgeon		
Pain Management		
Plastic Surgeon		
Psychiatrist		
Pulmonologist		
Rheumatologist		
Urologist		
Other:		
Other:		
Other:		
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Other:		
Other:		
Other:		
Other:		

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Office Visit Charges Notice of Responsibility at Time of Service

Patient Name: _____ Doctor: _____

Patient DOB: _____ Today's Date: _____

Office Visit Responsibility at Time of Service:

1) For All Patients:

   Because of the changes associated with the Affordable Care Act, beginning in 2014, most patients will be responsible for significant portions of their healthcare costs as out of pocket expenses. As a consequence, Karle Medical Group has determined that it is necessary to collect deductibles, co-pays, and co-insurances at the time of service for any patient seeing a healthcare provider for which such patient expenses are customary. Please be aware that when calculating such expenses, we err on the side of caution on your behalf, so balances will be calculated for patients with deductibles and co-insurance for only the office visit portion of the charges and not for any in office labs or procedures.

2) For HMO Patients Only:

   Normally my HMO insurance requires that I be assigned to a Primary Care Physician (PCP) prior to my insurance coverage being engaged for office visit coverage at a PCP's office. If I have chosen to postpone my assignment to one of the Karle Medical Group medical practitioners as my PCP until after I complete my initial office visit I accept responsibility for any and all charges associated with my office visit in the event that I decide not to assign a Karle Medical Group physician as my PCP office.

I, _____, have read this patient information sheet and acknowledge that the requirement of this form and my acceptance of responsibility for office visit charges is standard practice for my insurance in cases such as this.

_____ _____
Patient Signature Date

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