Karle Medical Group, P.C.
455 Barclay Circle, Suite D
Rochester Hills, MI 48307
T: 248-852-9596 | F: 248-852-9453

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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:_____

* U.S. government required statistical data necessary for all healthcare entities to attain "Meaningful Use" of Electronic Health Records.
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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

_____
Print Name of Witness

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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		

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Office Visit Charges Notice of Responsibility at Time of Service

Patient Name: _____ Doctor: _____

Patient DOB: _____ 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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