Mark Airais, MD, PC
21600 Harper Ave, Ste 100, St. Clair Shores, MI 48080
Phone: 586-800-1001, **Fax:** 586-800-1002

HIPAA Privacy practices

HIPAA is the federal health insurance program portability and accountability act. This US law is designed to provide privacy standards to protect patients' medical records and other health information products provided to health plans, doctors, hospitals and other healthcare providers. This is used to provide the patients access to their medical records and give the patient more control over how personal medical information is disclosed. I understand that in order for Bi-County Physicians to provide me with the best medical care possible, I must follow instructions and notify the facility if I experience any problems with my treatment. By acknowledging the terms of Bi-County Physicians, HIPAA privacy practices protected health information will be shared amongst healthcare providers to provide a continuum of care.

I acknowledge that Bi-County Physicians has explained this practice to me and will authorize the following:

I do_____ do not_____ give my permission for the doctor/staff to leave a message on my answering machine.

I do_____ do not_____give my permission for the doctor/ staff to speak to the persons listed below about my protected health information including test results, diagnosis, etc if I can not be reached:

Name _____ **Relation**_____ **Phone#**_____

Name_____ **Relation**_____**Phone#**_____

I do hereby authorize Bi-County Physicians to send any specimen ordered by the doctor to the laboratory for further diagnostics. I understand any fee that should accompany the testing is billed by and from the laboratory not Bi-County Physicians and that any co-pays and our deductible is associated are my responsibility.

Signature_____ **date** _____

Parent or guardian_____ **date**_____

Patient Name _____

Date of Birth _____

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CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Consent to Treat: I request and authorize the type of health care services that my physician(s), or their designees, advise. These may include routine diagnostic, radiology and laboratory procedures, therapeutic procedures, drugs, and medical, nursing, and hospital care. I understand that Bi-county Physicians has a role in teaching future health care personnel and that students and trainees may participate in my health care. Information Release. I give consent to Bi-county physicians to release information from my medical record for treatment, payment or healthcare operations purposes, including without limitation the following:

- ❑ Information about communicable diseases and serious communicable disease and infections as defined by statute and Michigan public health rules, which include sexually transmitted infection "STI", tuberculosis "TB", and human immunodeficiency syndromes such as "HIV" and "AIDS"
- ❑ Substance abuse treatment information protected by 42 Code of Federal Regulations Part 2.
- ❑ Psychological and social services information including communications made by me to a psychologist or social worker.

Consent to Video Monitoring: I consent to the use of video monitoring devices at Bi-county Physicians for patient and staff safety purposes.

Patient Data and Authorizations: The information given by me for payment is correct. I understand that being assigned to the correct PCP is my responsibility (Patients with HMO insurance type)

Payment: I agree to promptly pay Bi-county Physicians any charges not covered by or collected from an applicable health care benefits insurer. I know the facility's charges may be discounted under its charity care or discount policies. I agree to pay the facility's reasonable attorney's fees and collection agency expenses connected with the collection effort due to my not promptly paying for services provided. I know I am financially responsible for services except where contrary to law.

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Telephone Contact: I agree, in order for Bi-county Physicians to service my account or to collect any amounts I may owe, the facility may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. The facility may also contact me by sending text messages or emails, using any email address I provide to the facility. Methods of contact may include using pre recorded/artificial voice messages and/or use of an automatic dialing device.

NOTICE

Please be advised that the Facility may perform an HIV test upon a patient without any special written consent if a health professional, health facility employee, police officer, fire fighter, medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic sustains a percutaneous, mucous membrane, or open wound exposure to the patient's blood or other bodily fluids. These exposures may occur in the health facility, while the patient is treated before transport to the health facility or while the patient is transported to the health facility. An HIV test will also be performed pursuant to a request under MCL 333.20191 (2).

Patient Name _____

Patient Signature _____

Date _____

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Patient No-show and Late Cancellation Policy

Dear Patients,

To allow patients access to timely medical care, **we require that you call us at least 24 hours prior to your scheduled appointment to cancel or reschedule.**

1.I understand that I will be charged a **LATE CANCELLATION fee of $25** if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a **No-Show Fee of $25** if I fail to show to my scheduled appointment.

Patient Name_____

Patient Signature_____

Today's Date_____