Gregory E. Gould, D.O., P.C.

Name:	Date of Birth:

The Patient-Provider Partnership Agreement

The health and wellness of our patients is our primary concern. We strive to provide the best possible care to every patient. The only way we can meet this goal is by working together. This concept is called Patient Centered Medical Home (PCMH).

As our patient, your responsibilities are:

- Ask questions, share your feelings, and be an active part of your care.
- Be honest about your history, symptoms, and other important information.
- Tell your healthcare team about any changes in your health and wellbeing.
- Take all your medications and follow your doctor's advice
- Make healthy lifestyle decisions.
- Prepare for and keep scheduled visits. Reschedule visits in advance whenever possible.
- Call us first with all problems, unless it is a medical emergency.
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans.

As your provider, our responsibilities are:

- Explain diseases, treatments, and results in an easy to understand way.
- Take time to listen to your feelings and questions, and help you make decisions about your care
- Keep your treatments, discussions, and records secure.
- Provide 24-hour access to medical care and same day appointments, whenever possible.
- Provide instructions on how to meet your health care needs when the office is not open.
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Provide you with clear directions about medicines and other treatments
- When necessary, direct and coordinate your care through referrals to specialists and community resources
- End every visit with clear instructions about expectations, treatment goals, and future plans

I look forward to our partnership,

Gregory E. Gould, D.O.

_____ _____

Patient Signature Date

Gregory E. Gould, D.O., P.C.

Patient Demographic 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-RP (Subscriber/Insurance Contract Holder) 4 bolded items are required if you <u>are not the insurance subscriber</u>

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.

_____ _____

Patient Signature Date

* U.S. government required statistical data necessary for all healthcare entities to attain "Meaningful Use" of Electronic Health Records. Please return this document to the Gregory E. Gould, D.O., P.C. reception desk upon completion

Gregory E. Gould, D.O., P.C.

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 Gregory E. Gould, D.O., P.C. 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 Gregory E. Gould, D.O., P.C.

Spouse: _____ Relative: _____ Other: _____

Protected Health Information Messages

I **authorize** _____ /**prohibit** _____ the communication of detailed health information by the staff of Gregory E. Gould, D.O., P.C. in the form of voice-mail or answering-machine messages at my contact telephone number.

_____ _____

Patient Signature Date

Print Name of Signatory _____

Witnessed Date _____

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HIPAA Form E Notice and Acknowledgement

I acknowledge that I have reviewed the Gregory E. Gould, D.O., P.C. Notice of Privacy Practices or that I have waived the right to read the Gregory E. Gould, D.O., P.C.'s Notice of Privacy Practices document.

_____ _____

Patient Signature Date

Print Name of Signatory _____

If Signatory Not Patient, Please Indicate Relationship to Patient _____

Gregory E. Gould, D.O., P.C.

Office Policies

We at Gregory E. Gould, D.O., P.C. 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 Gregory E. Gould, D.O., P.C.'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 (586)372-3500 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 $50.00 or all appointment types with exception of physical, in which case 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.

Photographs may be used in your chart and become part of your medical record.

Portions of the office and parking lot are under video surveillance.

Individuals requiring controlled substances will have urinalysis or blood drug screening for other prescribed or non-prescribed substances. This may be repeated on a random basis or at the discretion of the healthcare provider. Certain controlled substances require monthly visits in the office. This may be of direct cost to you the patient.

Any outstanding balances are expected to be prior to future or upcoming appointments.

I understand and agree to adhere to the Gregory E. Gould, D.O., P.C. office policy.

_____ _____

Patient Signature Date

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Gregory E. Gould, D.O., P.C.

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 Gregory E. Gould, D.O., 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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Gregory E. Gould, D.O., P.C.

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 Gregory E. Gould, D.O., 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 Gregory E. Gould, D.O., 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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Gregory E. Gould, D.O., P.C.

Current Medication List

Name:	**Date of Birth:**

List all prescription and 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.)

Name of Medication	**Dose of Medication**	**Frequency Taken (How Often)**	Reason for Taking

Allergies/Sensitivities

Allergic to	**Reaction**

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Gregory E. Gould, D.O., P.C.

Patient Portal Form

In order to provide you with the best possible care that we are able, we ask that you provide Gregory E. Gould, D.O., P.C. 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 for Portal Access: _____

Relationship of individual being granted access (if not self): _____

(Initial)_____ I would like the patient portal invitation sent to me or another individual I grant access to.

(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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Gregory E. Gould, D.O., P.C.

Office Visit Charges Notice of Responsibility at Time of Service

Name:	Date of Birth:

Office Visit Responsibility at Time of Service:

1. 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, Gregory E. Gould, D.O., P.C. 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. 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 Gregory E. Gould, D.O., P.C. 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 Gregory E. Gould, D.O., P.C. 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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