Bashar Yaldo, M.D.

Name _____ Pharmacy Name _____

Email _____ Pharmacy Location _____

Primary Care Physician _____ Ethnicity: Are you Hispanic? Yes No Decline to Specify

Reason for today's visit _____ **Race:** American Indian or Alaskan Native Asian

_____ Black or African American Native Hawaiian/Pacific Islander

_____ White Declined to Specify

Location/Duration of Symptoms _____ Preferred Language: _____

_____

_____

Current Symptoms (Please check below if experiencing any of these symptoms)

	General Health		**HEENT**		**Cardiovascular**
	Chills		Burning /Pain of Eyes		Shortness of Breath
	Change in Appetite		Nasal Discharge		Chest Pain/Tightness
	Change in Weight		Ear Pain		Loss of Consciousness
	Weakness		Sore Throat		Ankle Swelling
	Respiratory		**Gastrointestinal**		**Hematology**
	Cough		Nausea/Vomiting		Yellow Skin/Eyes
	Wheezing		Constipation/Diarrhea		Gum Bleeding
	Shortness of Breath		Heart Burn		Frequent Bruises
	Urinary		Bloating/Abdominal Distention		Excessive Bleeding
	Incontinence		Difficulty Swallowing		Swollen Lymph Nodes
	Blood in Urine		Abdominal Pain		**Neurology**
	Painful Urination		Blood in/or Black Stool		Headaches
	Urethral Discharge		Rectal Bleeding/Pain		Seizures
	Musculoskeletal		Hemorrhoids		Weakness of Limbs
	Joint Pain/Swelling		**Skin**		
	Muscle Pain		Rash/Itching		
	Back Pain		Skin Sores		
			Moles		

Do you smoke? **Yes No Quit** How long? _____ How much? _____

Do you drink alcohol? **Yes No** How long? _____ How much? _____

Do you use recreational drugs? **Yes No** Type? _____ How often? _____
(including medical marijuana)

Past Medical History: (check None if applicable) **NONE** ❑

- Heart Attack Yes No
- Cancer Yes No → Type: _____
- Asthma Yes No
- Thyroid Disease Yes No
- Bleeding Disorder Yes No
- Angina Yes No
- High Blood Pressure Yes No
- Arrhythmia Yes No
- High Cholesterol Yes No

Diabetes Yes No → Type: 1 ❑ 2 ❑

COPD: ↓

Emphysema Yes No

Chronic Bronchitis Yes No

GERD/Acid Reflux Yes No

Other: (please list below) _____

Past Psychological/Psychiatric History: **NONE** ❑

_____

Family Medical History: (do not list names)

Father: _____ Mother: _____

Brother(s): _____ Sister(s):_____

Past Surgical History: **NONE** ❑

- Colonoscopy Yes No Date_____
- Mammo Yes No Date_____
- EGD (Upper Scope) Yes No
- Gallbladder Yes No
- Appendectomy Yes No
- Breast Yes No → Type: _____
- Hernia Yes No → Type: _____
- Other:(please list) _____

Allergies: **NONE** ❑

_____

_____

Current Medications with Dosage: **NONE** ❑

_____

_____

_____

Vitamins / Herbal Supplements:_____

Bashar Yaldo, M.D. PC.

Patient Financial Responsibility Statement

Thank you for choosing Dr. Bashar Yaldo, M.D. as your surgeon. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Please feel free to ask us if you have any questions or concerns. If someone else (parent, spouse, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them as it explains our practices regarding insurance billing, copayments and patient billing. By signing below and/or by receiving medical services from Dr. Bashar Yaldo, M.D., you agree:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts and any other patient responsibility indicated by your insurance carrier which are not otherwise covered by supplemental insurance if applicable. This includes Medicare policies.

2. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if the following applies: Your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services and we do not have it on file in our office by the time of the appointment. Please note: we will assist in any way we can to facilitate this but it is ultimately the patient's responsibility. If you are unfamiliar with your plan coverage, we recommend you contact your insurance carrier.

3. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other outstanding account balances at each visit or before your scheduled procedure. Your insurance cards must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our office visit fee and/or procedural fees are expected to be paid in full at the time of service. If the insurance card is furnished after the visit, we will file a claim with them and reimburse you the amount the insurance company paid for that visit. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled. In certain instances, because of large deductibles with insurance plans, you may be required to pay in advance for procedures. You are welcome to discuss these financial obligations with us.

4. We will verify your insurance benefits or submit your claim to your insurance company as a courtesy to you. You authorize Dr. Bashar Yaldo, M.D. P.C. to release patient information acquired in the course of your examination and/or treatment deemed necessary to process claims to your insurance company in order to process payment for those services. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims and you will be responsible for the balance. Dr. Bashar Yaldo, M.D. P.C. does not accept responsibility for incorrect information given by you or your insurance carrier regarding your benefits.

5. Payment of any account balances is due within 30 days of receiving a statement. If payment arrangements and/or payments are not followed, your account will be placed in collections. We accept payment by cash, check, money order, credit/debit card. If a check is returned for insufficient funds, you will be charged an extra $25.00 returned check fee.

6. **Workers' Compensation Cases**. Charges for services incurred as a result of a verified work-related injury will be treated as workers' compensation and we will bill the workers' compensation carrier as a courtesy. You must provide an open claim letter from your employer and/or carrier at your first appointment. If your claim is denied, you will also provide us with your medical insurance information so we can forward the claim to them for payment. At that point, you will be responsible for all deductible/coinsurance amounts after the claim has been paid.

7. **FMLA/Disability.** Fee for FMLA/Disability paperwork to be completed by our office is $50.00 before paperwork is completed. Payment by cash, check or charge is acceptable.

Acknowledgement:

By signing below, each of the undersigned acknowledges that I have read, understand and agree to the provisions and terms outlined in this statement.

_____ _____

_____ _____

Patient/Responsible Party/Guardian Date

Notice of Privacy Practices: Acknowledgement of Receipt

BASHAR YALDO, MD is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for: BASHAR YALDO, MD PC

Patient/Authorized Representative Signature _____

Patient Name (print) _____

Date _____

PCMH-N

PATIENT PROVIDER PARTNERSHIP

For Specialist Care

At the office of Bashar Yaldo, MD our goal is to provide you with the highest standard of specialty care. Your care will be coordinated with your Primary Care Physician who acts as your Patient Centered Medical Home (PCMH), as we are part of the Patient Centered Medical Home Neighborhood. Below are some guidelines to our patient and provider commitment.

Physician Commitment

I as your physician I am committed to providing the highest quality of patient care. I am committed to ensuring your rights as a patient, including your right:

- To be treated with respect and dignity.
- To schedule your appointments as soon as possible.
- To have open and honest discussions with you regarding your health and plans for managing your care
- To explain diseases, treatments, and results in an easy to understand way.
- To be available to you by phone and in the office to answer questions and concerns

Patient Commitment

We ask that you make every effort to commit to:

- Keep and arrive on time to all scheduled appointments. Cancel or reschedule appointments whenever possible.
- Follow through with recommended testing.
- Be honest about your history, symptoms, and other important information about your health.
- Take your medication(s) as directed and follow your doctor's advice.
- Follow up with your Primary Care Physician for your overall healthcare needs.

Signature

I have read and understand this agreement.

_____	Bashar Yaldo, MD.
Printed Name of Patient	Printed Name of Physician
_____	 _____
Signature of Patient	Signature of Physician
_____	_____
Date	Date

CONSENT FORM FOR PRACTICE EMAIL

PHYSICIAN-PATIENT EMAIL COMMUNICATION POLICY

To better serve our patients, Dr. Bashar Yaldo, MD PC has established an email address our patients may use to communicate with the practice. It is just one of several communication options we make available to our patients.

OUR POLICY: Patients of Dr. Bashar Yaldo, MD have the option of communicating with the doctor or office manager/surgical scheduler. Prior to doing so, we ask that you review this policy sheet and sign it below.

Please note that copies of all email communications between you and this practice will be placed in your medical records and treated like other information contained there.

When sending an email to this practice, use our email address, byaldomd@gmail.com. Please include your full name and date of birth. You may email us for routine matters that do not require immediate response. DO NOT use email communication in an emergency or urgent situation. Please use the office phone number, 248-858-3700, or call 911. Also, for your privacy, some issues are not appropriate for email discussion. Communication appropriate for email includes: scheduling, billing or insurance questions and other non-urgent medical advice.

Email is monitored daily. If you do not receive a response within 2 business days, please contact the office for follow up.

Our office is committed to keeping your medical information private, including any information sent to us by email. However, email security cannot be guaranteed as messages are transmitted via the Internet. For that reason, please do not use email for anything you want kept confidential.

If you have any questions about this policy, please speak with the office manager. If you understand our email policy and would like to add email to the ways you communicate with us, please sign and date below.

Date_____ Signature_____

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Name: _____

I hereby authorize the office of Dr. Bashar Yaldo, MD, PC to use or disclose my protected health information related to my care to (ie. family/friend) _____ for the following purpose: **Continuity of Care**

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office and/or person that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____

Date Signature of Individual or Representative

_____

Authority of Relationship to Individual, if Representative

Expiration Date: This authorization will expire on _____. If no date or event is stated, the expiration date will be six years from the date of this authorization.