Dear Patient,

Welcome to our Office and Infusion Center. Enclosed, please find your registration materials.

You were referred to Okemos Infusion Center by your physician for infusion services. You are required to see one of our providers in order to admit you for your infusion treatment. Although we are not managing your disease state, we are managing your infusion treatment.

You will continue to see the provider that sent you to us for follow-up appointments. Additional appointments with one of our providers will be required annually. This will comply with insurance regulations and to provide information to your referring provider about how your treatment is tolerated. We will remain in close contact with your physician to ensure your treatment is administered according to their treatment plan.

PLEASE BRING OR PROVIDE A DETAILED LIST OF ALL YOUR MEDICATIONS.

Regards,

Lawrence Hennessey, M.D.
Manoj Mohan, D.O.
Andrea Miller, FNP-BC

ADULT PATIENT REGISTRATION FORM

(P l e a s e P r I n t)

Personal Information

Check here if you have ever been seen by our office prior to today's appointment. _____

Name:_____

Street
Address:_____

City: _____ State: _____ ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Sex: Male _____ Female: _____

Date of Birth: _____

Race: _____

Ethnicity: _____

EMAIL ADDRESS: _____

Employed? ____ Yes _____ No _____ Retired

Your Employer: _____

In Case of Emergency Contact:

Name: _____

Phone:_____

INSURANCE INFORMATION

(Please Present All Insurance Cards to Staff)

Primary Insurance Carrier: _____

Subscriber's Name: _____

Relationship to Patient: _____

Date of Birth: _____

Billing Address (if other than patient's):

_____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

Secondary Insurance Carrier: _____

Subscriber's Name: _____

Relationship to Patient: _____ _____

Date of Birth: _____

Billing Address (if other than patient's):

_____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

FINANCIAL POLICY

Thank you for allowing us to be part of your health care team. In order for us to provide the best possible care and to maximize your medical insurance policy coverage, you must provide accurate insurance information. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, or address.

The relationship you have with your insurance company and employer is a contract of which we are not part of. Our billing staff will process your claims for you, and answer any questions you may have.

Please be advised that, regardless of your insurance status, final responsibility for payment of our services is your obligation.

It is the patient's responsibility to make sure proper prior authorizations and referrals are made and updated when needed.

Co-payments are due at the time of service. A $5.00 Service Charge will be added if you do not pay your Co-Pay at Check-In.

The Infusion Center Team has already verified and confirmed authorization for your infusion treatment. Any questions can be directed to our infusion center. Please call 517-455-7880.0

I have read and understand the conditions set forth, and I authorize the treatment of and also the release of any medical or other information necessary to process the insurance claim(s). I also request payment of medical benefits be made directly to Okemos Allergy Center, P.C.

_____ _____

Signature (Responsible Party/Subscriber) **(Date)**

GUARANTEE OF PAYMENT FOR SERVICES

In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

There are some insurance companies that require an authorization before an office visit or service will be paid; others have their own insurance guidelines about when a visit to a specialist's office will be covered. ***It is your responsibility to know the extent of your insurance benefits and to confirm any required authorizations have been done.***

If, for any reason, your insurance company chooses not to cover your infusion services, you will be responsible for payment at the time of service. This includes all future visits. The estimated cost for a visit can be provided to you in advance.

Your signature below indicates that you will be responsible for payment in full should you fail to obtain an authorization, or should your insurance company choose not to pay for your visit.

I,_____, have read and agree with the above statement, and further agree to be responsible for all charges incurred, or to provide written approval authorization from my insurance company for all visits and procedures prior to being seen.

_____
Patient Signature

Date: _____

IN ORDER TO SHARE CHART/BILLING INFORMATION WITH ANY FAMILY MEMBERS (INCLUDING SPOUSES) YOU MUST PROVIDE PERMISSION. PLEASE COMPLETE THIS FORM. (THIS FORM IS OPTIONAL)

Limited Patient Authorization for Disclosure of Protected Health Information Form

Please print all information. Authorization will remain in place unless we are notified in writing.

Patient Name: _____

Date of Birth: _____

Purpose of request (who will be authorized to receive information) - I authorize Okemos Allergy Center to disclose or provide my protected health information to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI)**:**

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3._____	_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person, or persons identified above:

- ☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
- ☐ office notes
- ☐ nursing home, home health, hospice, and other physician records
- ☐ lab results, pathology reports
- ☐ record of HIV and communicable disease testing
- ☐ x-rays/Imaging

* You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
* The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
* We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or representative Signature: _____ Date: _____

Notice of Privacy Practices Form Okemos Allergy Center, P.C.

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information.
Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e.name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided in the section "Privacy Complaints".

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your

prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare service we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or
death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law
enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at: Okemos Allergy Center, P.C., 3955 Okemos Rd. Ste.A1, Okemos, MI 48864
We will not retaliate against you for filing a complaint.

Effective Date: 07/08/2013

PRIVACY NOTICE ACKNOWLEDGMENT FORM

I, _____
acknowledge that I have received a copy of the Privacy Notice of Okemos Allergy Center, P.C.

_____
Patient's Signature (or Legal Guardian if patient is a minor)

_____
Witness' Signature

Date: _____