DATE: _____

PATIENT IDENTIFICATION: PLEASE PRINT

PATIENT'S LAST NAME		FIRST		MIDDLE
AGE / DATE OF BIRTH		STREET ADDRESS		APT#/LOT#
CITY	STATE	ZIP CODE	SOCIAL SECURITY #	EMAIL ADDRESS
HOME/CELL PHONE	BUSINESS PHONE	MARITAL STATUS	❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED	
PATIENT'S OCCUPATION	EMPLOYER'S NAME	ADDRESS		
PERSON TO NOTIFY IN CASE OF EMERGENCY			TELEPHONE #	
PRIMARY CARE PHYSICIAN			TELEPHONE #	
REFERRED BY:	❑ PHYSICIAN _____ ❑ PATIENT _____		❑ INSURANCE COMPANY ❑ ADVERTISEMENT ❑ YELLOW PAGES ❑ OTHER _____	

INSURANCE AND ID:

PLEASE PRESENT YOUR INSURANCE CARD AND PICTURE IDENTIFICATION TO THE RECEPTIONIST

CREDIT CARD AUTHORIZATION FORM

I, (PLEASE PRINT NAME)_____, AUTHORIZE THE INSTITUTE FOR PERSONALIZED MEDICINE, LLC TO CHARGE MY CREDIT CARD FOR THE FOLLOWING REASONS: OFFICE VISITS, MAIL ORDERS/PRODUCTS, PHONE CONSULTATIONS AND CANCELLATION FEES.

CREDIT CARD (PLEASE CIRCLE ONE) VISA MASTERCARD AMERICAN EXPRESS

CARD NUMBER:_____ EXPIRATION DATE:_____

3 OR 4 DIGIT SECURITY CODE:_____

BILLING ADDRESS FOR LISTED CREDIT CARD:_____

SIGNATURE OF CARD HOLDER:_____

DATE: _____

- I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT.
- I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY AND ABSOLVE THE INSTITUTE FOR PERSONALIZED MEDICINE AND THEIR PHYSICIANS OF ANY LIABILITY AS A RESULT OF FAX ERRORS.
- I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE INSTITUTE OF PERSONALIZED MEDICINE'S FINANCIAL POLICY AND TAKE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY THE PHYSICIANS OF THE INSTITUTE FOR PERSONALIZED MEDICINE.
- I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.
- I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

DATE SIGNATURE

Institute for Personalized Medicine Office Policies – Please initial each item and sign at the bottom as indicated.

Our office is an **out** of network fee for service provider. We do not file claims to insurance for office visits. You will be provided a super bill to submit to your health insurance plan for possible reimbursement. _____(initial)

1. Labs drawn for your appointments are billed directly to your insurance by LabCorp (or other laboratory). The Institute for Personalized Medicine and Dr. Ross are **not** involved whatsoever in the relationship and/or billing between LabCorp and your insurance carrier. _____(initial)

2. **Payment is due from you at the time of service.** Methods of payment include cash, check and major credit cards. If you elect to pay with a credit card, a 3% processing fee is added to all charges to offset merchant fees. _____(initial)

3. If the time you spend with a physician exceeds your allotted scheduled time, you will be charged for the additional time spent with a physician. Please review our office fee schedule for additional information. _____(initial)

4. Lab results are reviewed and discussed only during scheduled appointment times. Lab results are not provided to you prior to being reviewed with a physician. _____(initial)

5. **All services and product sales are final.** Patients are responsible for payment of services and products sold. We do not issue refunds _____(initial)

6. We require a credit card to be kept on file for patients in the event that products, etc. are requested to be mailed to you. This card will also be used for appointment cancellation fees and/or returned checks. _____(initial)

7. Our office is a highly specialized practice offering functional medicine and bio-identical hormone replacement therapy. **We do not assume the responsibility for treatment of major medical illnesses that you are currently being treated for by your primary care physician.** Please continue treatment with your primary care physician or OB/GYN for routine medical problems. All patients must be current with all routine health screening exams (i.e. mammograms, pap smears, colonoscopy, etc.) _____(initial)

Functional patients: 1 hour or less $550 Each additional 15 minutes $137.50

Bredesen Protocol patients: 1 hour or less $650 Each additional 15 minutes: $162.50

8. **You will be charged a missed/cancelled appointment fee equal to the cost of your visit if you cancel your scheduled appointment with less than 3 days notice or if you simply do not show up for your appointment. _____(initial) Your credit card on file will be billed for missed appointment fees- if your card declines or cannot be billed, you agree to be billed and pay the required appointment fee. _____(initial)**

By my initials above and by signing below, I acknowledge that I have read this document and agree to abide by the office policies and fee schedule.

Signature:_____ Date signed:_____

Patient's name (Print):_____

Staff initials and Date Received: _____

Institute for Personalized Medicine

I (please print) _____, understand that I am seeking healthcare from a physician that does not participate with the Medicare program, and that any charges incurred as a result will be my financial responsibility and will NOT be billed to the Medicare program or my supplement.

_____
Signature

_____
Date

Institute for Personalized Medicine
Mary Kay Ross, M.D., FACEP
3 Johnston Street
Savannah, GA 31405

AUTHORIZATION TO RELEASE PERSONAL HEALTHCARE INFORMATION TO SPECIFIC INDIVIDUALS*

Please check one of the following statements

I DO authorize the release of my personal healthcare information to _____ (print name of specific individual and check relation).

- **_____ spouse**
- **_____ relative**
- **_____ other i.e. friend or significant other**

I DO NOT authorize the release of my personal healthcare information to any individual _____ (please initial).

***Please note that if you choose not to disclose personal healthcare information to any individual it is possible that your healthcare may be delayed if we are unable to contact you directly. You may change or withdraw your authorization at any time in writing.**

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

Contact Preference Form

Federal law now requires that we obtain permission to contact you by phone, leave messages or to discuss your confidential healthcare information with any third party. Please review the following statements and check your preferences. This form will become part of your medical record, and must be rescinded in writing.

- ☐ I may be called at home.
- ☐ I may not be called at home.

- ☐ The office may leave a message at my home.
- ☐ The office may not leave a message at my home.

- ☐ The office may call my place of employment.
- ☐ The office may not call my place of employment.

- ☐ The office may leave messages at my place of employment.
- ☐ The office many not leave messages at my place of employment.

- ☐ I authorize the release of my personal healthcare information to: _____
  (Print name and relationship to individual.)

_____

Signature Date

Institute for Personalized Medicine Privacy Practices

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

You may be worried about keeping your health and medical information private, we understand. There are laws and ways health care providers can use and share medical information about patients. The law says that we need your permission (authorization) for certain uses, but not others.

Your personal medical information is called Protected Health Information or "PHI". The law allows us to use your PHI without your permission for the purposes of medical Treatment, insurance Payment or for business Operations TPO). Examples are the following:

- **Treatment:** Any medical staff involved in treating you can use your PHI. They can also share it with others involved in your care. For example if our office refers you to a specialist we may share your pertinent PHI with that office.
- **Payment:** We may use and share your PHI to collect payment for services. For example, we may give your PHI to your insurance company as requested for payment for services.
- **Operations:** We are continually striving to provide the highest level of service to our patients and in doing so we may from time to time use your PHI for business purposes such as, to manage our budget or evaluate the quality of our care.

As well there are other cases where we can share your PHI without permission. Examples are the following:

- **To Follow the Law:** We may share PHI to follow the law, to report or solve crimes or to help law enforcement.
- **To Protect Public Health:** We can give PHI to people who work to stop the spread of diseases. And we must report abuse and neglect.
- **To Help Coroners or Medical Examiners:** We may need to give PHI to help identify a body or the cause of death.
- **For Organ or Tissue Donation:** We may give your PHI to help agencies that match organ donors with people on waiting lists.
- **To Avoid a Serious Threat to Others:** We can give PHI to people working to prevent a threat to the health or safety of other people.
- **Special Government Functions:** We may share PHI with federal officials for national security reasons.
- **Workers' Compensation:** We can release PHI to comply with laws that protect you if you are hurt or get sick on the job.
- **Appointment Reminders and Other Items of Interest:** We can use your PHI to contact you about an appointment. We can also contact you about other treatments, services, and programs that may interest you.
- **Your Access to Your Own PHI:** We may share your PHI with you or someone you choose to represent you.
- **Government Offices:** We must give your PHI to certain federal workers when they are checking on how we follow the privacy laws.

We must have your written authorization to use your PHI for any other reasons than listed above. This notice tells you our rules for using PHI. We have to follow what we say in this notice. You may revoke this authorization to release your information, with some limitations, at any time in writing.

The law says we must keep your PHI private. It also says that we must tell you in writing:

- What the law says we can and cannot do with your PHI
- Our privacy polices regarding PHI

We have the right to change information and policies contained in this notice. A new notice must be given to you and posted in our office when changes are made.

You have certain rights under the privacy laws:

- You can ask us not to share your PHI with a person or group. Keep in mind we do not have to honor this request; we must only honor what we have set forth in this notice. No matter what, we can always share your PHI in an emergency.
- You can ask that we not contact you in certain ways or at certain places, such as work or home.
- You may ask that we fix mistakes or add new facts to your PHI. We will not honor these requests if: it wasn't written by us, contained in another physicians records released to our office, is not something you are allowed to see, or is not correct and complete.
- You may ask for a list of the people and groups who have seen your PHI within the past (6) years. This list will not include times when you gave your written permission to release your PHI.

You must make the above requests in writing. Your request should be sent to: Stephen Ross Privacy Officer, 413 W. Montgomery Crossroad, Suite 102, Savannah, Georgia 31406. We must reply to you within (30) days after receipt of your request. We will respond in writing with our determination.

You may request copies of this notice by contacting our office at (912) 352-1234. Copies are also posted within our office.

You may complain to us if you believe your privacy rights have been violated. You may contact our privacy officer Stephen Ross at our office. You also have the right to complain to the Secretary of the Department of Health and Human Services.

Receipt of Our Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by calling our office at (912) 352-1234 or by visiting our office.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Printed Name: _____

Patient/Responsible Party Signature: _____

Date: ____/____/____