

PAYMENT AUTHORIZATION/FINANCIAL AGREEMENT

This form is a release of information, benefit assignment, payment authorization, full disclosure statement, and agreement to pay for professional services.

I _____, authorize Allergy & Asthma Institute of SE Michigan, PLLC, to release any information acquired during the course of my examination or treatment to my insurance company for the purposes of processing my insurance/medical claim. I agree to allow a photocopy of my signature to be used to process my insurance/medical claim for the period of lifetime. I claim any insurance benefits due me for services rendered by Allergy & Asthma Institute of SE Michigan, PLLC and authorize and assign payment directly to Allergy & Asthma Institute of SE Michigan, PLLC, regardless of my insurance benefits.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to Allergy & Asthma Institute of SE Michigan, PLLC and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

All past due balances are assessed at 1 ½ % per mo. Finance charge after 60 days. Balances that reach 90 days are sent to a collection agency and the responsible party is liable for any charges and legal fees incurred by our office as a result of this action.

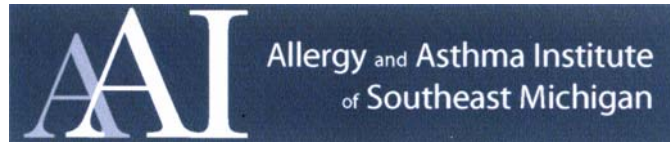
I have fully disclosed all information concerning the insurance/third-party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of nonpayment by any carrier.

Patient Name: _____

Patient/Guardian

Signature:	
Date:	

Allergy & Asthma Institute of SE Michigan
7010 Pontiac Trail, Suite B
West Bloomfield, MI 48323
Phone: 248-363-3232
Fax: 248-363-3455



Allergy & Asthma Institute of SE Michigan

Medical Record Number _____

Patient Name _____

Date of Birth _____
(if MRN not available)

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receiving a copy of the Allergy & Asthma Institute of SE Michigan, PLLC, Notice of Privacy Practices.

Signature or initials of patient or authorized representative* _____

Printed name of authorized representative (if applicable) _____

Date: _____

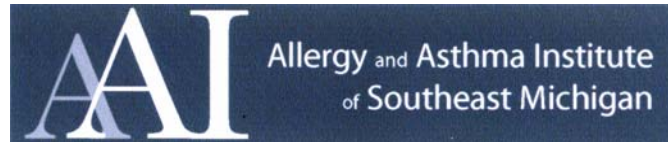
* Authorized representative include:

- Legal guardian
- Emancipated minor
- Patients between age of 14-18 seen for conditions not requiring parental consent

OFFICE USE

Date data entered into system _____

Comments:



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West Bloomfield, MI 48323

Phone: 248-363-3232; Fax 248-363-3455

www.AllergyAsthmaMichigan.com

AAISEMI@sbcglobal.net

Patient E-Mail Consent Form

The practice of Allergy & Asthma Institute of SE Michigan, PLLC offers patients the benefit of communication via e-mail. In addition to personal and telephone discussions, I _____ (Patient Name) would like to use e-mail as a method of communication with the Practice and have read and understand the following:

Privacy. I understand that e-mail may be used only for non-emergency questions and requests in the ordinary course of business and, as a result, persons employed by the practice will be responsible for access to and processing such communications.

I understand that confidential and sensitive information will never be shared with a third party without my written authorization. I also understand that there are certain situations in which Dr. Chad Mayer, DO may share my e-mail messages without written authorization (e.g., disclosures required by state or federal law). I also understand that if law requires a disclosure, only the minimum amount of information necessary to achieve the purpose of the request will be disclosed. Subsequently, I will receive notice that the disclosure was made.

Response Time. The Practice will make every effort to respond to your e-mail request within 1-2 business days. If, for any reason (such as vacation, illness, emergency), I am unavailable to answer your e-mail request within the designated timeframe, you will receive a response from another physician or employee from the practice authorized to address your e-mail.

Users will receive an automatic reply message from the practice to confirm receipts of an e-mail message. The message will state the expected office response time and include contact information if you need immediate assistance.

Permissible Uses. The Practice will allow e-mail use for medical advice and non-urgent or non-emergency matters including:

Appointments
Prescription refills
Billing/Insurance questions
Non-emergency Advice

Non-Permissible Uses. Prohibited uses of e-mail include but are not limited to:

- 1) Urgent or time-sensitive communications
- 2) Highly confidential or sensitive information, e.g., discussion of HIV status, mental illness, chemical dependency and workers compensation claims
- 3) Using e-mail to attach large database files or files containing inappropriate materials unrelated to the permissible uses defined above

If the practice feels the content or subject matter of an e-mail is inappropriate for an electronic response, it reserves the right to refuse communication via e-mail and will suggest alternate means to discuss the question or request. I understand that at no time should I expect a diagnosis, a recommendation of treatment or a prognosis via e-mail regarding a complaint or symptom for which the physician did not see me personally, regardless of whether the physician has seen me personally on prior occasions.

I understand that at any time the Practice may terminate e-mail communications with me and that I will be notified of such termination by a written letter. I understand that termination of online communication does not necessarily mean termination of the patient-physician relationship.

Patient Responsibilities. I understand that e-mail should be used only for appropriate messages and non-urgent situations. I agree to call the practice immediately if the situation escalates to a point where a phone call or visit is necessary. I also agree to do the following when making an e-mail request:

- 1) Choose the category of the transaction offered (e.g., prescription, appointment, medical advice, billing question).
- 2) Place my full name and patient ID in the first line of the body of the message.
- 3) Configure automatic reply to acknowledge receipt of the message, if possible.

I also understand that all messages, with replies and confirmation of receipt will be printed and placed in the patient's medical record, and it is the patient's duty to maintain their own copies of e-mail communications.

Security. The Practice has the following security mechanisms in place to secure confidential and sensitive information:

- 1) Encryption will be used for all messages when practical and always for confidential or private information.
- 2) Back-ups of data will be performed monthly onto a long-term storage.
- 3) Password protection allows access only to authorized users permitted to access and handle all office e-mail communications.
- 4) Password protected screen savers will be used on computers, including keeping all screens out of public view.
- 5) Information sent in a group mailing will maintain the confidentiality of the patient by using a blind copy to keep recipients invisible to each other.

Indemnification. You agree to indemnify, defend and hold harmless Allergy & Asthma Institute of SE Michigan, PLLC, its officers, directors, employees, agents and independent contractors from and against any and all losses, expenses, damages and costs arising out of your use of Patient e-mail, any activity related to your patient account information and any information lost due to technical failures.

Consent

I have read this consent, have been given the opportunity to discuss the issues with the practice and understand that by signing this consent I agree to the above policy and conditions established by this practice. I understand that I may also withdraw consent for the use of e-mail interactions at any time without affecting my right to future treatment.

Patient Name Date

Patient's Legal Representative Date

Email _____

Alternative Email _____