Rana Khoury MD PC

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Dearborn, MI 48124
Office (313)565-5101

PLEASE READ CAREFULLY

In order to provide excellent patient care, Dr. Khoury reviews new medical records to make a decision regarding prescription refills for any controlled prescriptions such as Norco, Xanax, etc. Obtaining your medical record can take up to 30 days to receive from your previous physician.

If you are on a pain medication after a recent hospital visit due to an accident, surgery, etc., in most cases this record is usually something we can obtain while you wait and make a decision.

For patients who have a history of chronic pain or severe anxiety that requires daily medication (with controlled substances), you will be referred to the appropriate specialist for your condition.

We want you to be aware of this policy in case it will affect your decision to become established with Dr. Khoury.

Thank you,

Dr. Khoury and Staff

_____

Patient Signature

Patient Registration

Patient Name _____ Patient Social Security Number _____

Street Address _____ City _____ Zip _____

Date of Birth _____ Marital Status **S M W SEP D** Sex **M F**

Telephone Number **Home** _____ **Work**_____ **Cell**_____

Where would you like us to call you first? Home ___ Work ___ Cell ___

Email _____ Race _____ Ethnicity _____

Occupation_____

Spouse Name _____ Spouse Telephone _____

Emergency Contact _____ Tel#_____ Relationship _____

Advanced Directive Education:
Do you have a will or advanced directive? Yes ___ No ___
Do you want information on Living Wills and Advanced Directives? Yes ___ No ___

How did you hear about us? _____

Other Doctors_____

Insurance Information

Primary Insurance _____ Effective Date_____

Subscriber Name _____ Relationship to Patient _____ DOB _____

Subscriber address(if different than patient) _____

Secondary Insurance _____ Effective Date _____

Subscriber Name _____ Relationship to Patient _____ DOB _____

Subscriber address(if different than patient) _____

Prescription Refills

Many medications require ongoing refills; however, it is possible to run out of your medication refills prior to your next appointment. It is important not to miss any doses of certain medications. Please call for a refill when you have at least 5 days of the medication remaining to avoid waiting unnecessarily at the pharmacy or missing any of your doses. If you have any questions about whether or not to continue a medication that has no more refills PLEASE call the office and we will give you the proper advice.

Emergencies

Our physicians are available 24 hours a day to meet your needs when emergencies occur. If you need urgent attention please go to the nearest emergency room or call 911. The emergency room physician will evaluate your medical problem and consult with Oakwood Internists Physicians when necessary. If you are uncertain what to do, please call our office and you will be provided with the information on how to proceed.

Hospitalization

When hospitalization is required our Physicians will see you at Oakwood Hospital, Main.

Referrals

We request a 3 day business notice to process referrals.

Follow up on test results

Usually we get most test results in 2 - 3 business days. Please be sure you understand your results and the follow up plan.

For abnormal test results an appointment is necessary to discuss the plan of care.

EFFECTIVE IMMEDIATELY

Any balance of $100 or more that's over 90 days old with no payment on account requires a payment with a credit card authorization to be set up for the balance to be paid in full at the time of the visit.

There will be a $25 no show fee assessed to your account for not showing up for your scheduled appointment without calling to cancel.

There will be a $5 per claim charge to all patients who receive 2 statements on an unpaid balance. This will apply to the 3rd statement and every one after. This is in addition to the balance. To avoid this fee, please pay for all services at the time they are rendered.

****PLEASE CHECK OUT A THE FRONT DESK FOR A COPY OF YOUR PRESCRIPTIONS AND ANY INSTRUCTIONS ****

Acknowledged by: _____ Date:_____

Dear Patient,
For your convenience and safety, we are introducing a computerized prescription program that will improve the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases it will accommodate the transmissions of your prescriptions to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy, however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone and fax) as any information provided will be helpful.

PATIENT NAME: _____ Date of Birth: _____

MAIN PHARMACY:

Pharmacy_____

Address_____

Phone _____ Fax _____

ADDITIONAL PHARMACIES YOU WOULD LIKE TO BE KEPT ON FILE:

Pharmacy_____

Address _____

Phone _____ Fax _____

Mail Order:

_____ Medco _____ Express Scripts _____ Caremark _____ Pharmacare

Are you interested in getting your test results and requesting prescription refills electronically online?

Yes ☐ No ☐

If yes, please provide your email address:

_____

Current patients only:

Do you find this option user friendly? Yes ☐ No ☐

Would you like to opt out? Yes ☐ No ☐

Signature _____ Date _____

Patient Consent

Consent to treat & Financial Authorization

I hereby authorize my provider to treat my symptoms and apply for benefits on my behalf for any services rendered by him or his order. I request that all payments of authorized benefits from Medicare/Insurance benefits can be made directly to my provider. I authorize the provider to release any medical information about me to HCFA/my insurance and its agents, any information needed to determine these benefits or the benefits payable to related services. I authorize the use of this authorization for any of my insurance submissions. I understand that I am responsible for any amount not covered by my insurance company(s). I certify the information that I have reported with regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place of its original. This authorization may be retrieved by either me or by insurance company at any time in writing.

Patient Signature _____ Date _____ Parent Signature _____ Date_____

RX History Consent

I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to determine the pharmacy benefits and drug copays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to those pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature_____ Date _____ Parent Signature _____ Date _____

HIPPA Consent

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

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentially agreements and are required to comply with our confidentially policies.

We may use or disclose your protected health information for purpose of treatment, payment or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or discussed while the consent or authorization is in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefit programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services. You may want a friend or family member to discuss care with a physician(s), or staff member, take messages, and pick up prescriptions or other medically related communications.

- Please indicate if there is a friend or family member who we are allowed to release medical information to:

  Name_____ Phone _____ Relationship _____

  Name_____ Phone _____ Relationship _____

- You may also identify a friend or family member to whom we are specifically restricted from releasing medical information to:

  Name_____ Phone _____ Relationship _____

You have the right to access and amend your information, request an accounting of any disclosures, requesting restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised copy by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the US Department of Health and Human Resources. We will not retaliate against you for filing a complaint.

For more information, please contact us at: 313-908-9374 This notice is effective 2/29/2012

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices:

_____ _____

Signature Date