Manella
FAMILY PRACTICE

500 N. Hiatus Rd., Suite 201
Pembroke Pines, FL 33026
(954) 381-8989

PATIENT INFORMATION

Name: (L/F/M) _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS #: _____ Date of Birth: _____ Sex: M ____ F ____

Marital Status: M ____ S ____ D ____ W ____ Spouse Name: _____

Telephone #: _____ Can we leave a message at this number regarding appointments/results? Yes ____ No ____

Cell Phone #: _____ Can we leave a message at this number regarding appointments/results? Yes ____ No ____

Email Address: _____ Can we leave a message at this address regarding appointments/results? Yes ____ No ____

Patient's Place of Employment: _____ Occupation: _____

Work Telephone #: _____ Can we leave a message at this number regarding appointments/results? Yes ____ No ____

Emergency Contact: _____ Relationship: _____

Telephone #: _____ Primary Language: _____

How did you hear about us? _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's SS #: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Telephone #: _____ Effective Date: _____ Termination Date: _____

ADVANCE DIRECTIVE

A. Do you have a Health Care Surrogate? Yes: _____ No: _____

Name of Health Care Surrogate: _____ Relationship: _____ Telephone #: _____

B. Do you have a Living Will? Yes: _____ No: _____

Person that a representative can speak to regarding my conditions: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize that the information contained in my chart, on my registration form, is correct. I understand this information is necessary for the processing of my claims and to ensure proper medical care. I authorize Manella Family Practice, LLC and its physicians to treat me. I authorize the release of my medical or any other information necessary to process any claims. I also request payment of governmental benefits either to myself or to the party who accepts assignment and payments of medical benefits to Manella Family Practice, LLC by my insurance company for services provided. I agree that I am responsible for all charges which are not authorized as covered by my insurance company or government agency.

Signature: _____ Date: _____

To Our Patients:

We thank you for choosing Manella Family Practice, LLC for your medical needs. Our office has instituted a registration policy that allows us to provide exceptional care in a more efficient manner. We re-evaluate our processes and protocols on a continuous basis, and take your feedback and suggestions into account when designing or re-evaluating our protocols.

We have implemented a style of practice that allows us to dedicate the time needed for each patient and have developed a "patient-first" model which includes the following advantages for our patients:

- Appointment slots are not overbooked
- Patients are not required to return to the office for normal lab results
- Blood is drawn on site
- Coordination care with specialists
- Extended evening hours

In order for us to continue to provide these services in the manner we have streamlined the registration process. This process is similar to industries that you are familiar with such as airlines, hotels, and car rental companies. For example, if you have ever checked into a hotel or rented a car, you are asked for a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes check out faster and more efficient. We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance has paid its portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

We assure you that your information is safe. We are required to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) federal law. **We take this very seriously.**

You will no longer have to write out and mail us checks. Which will decrease the number of statements that the practice must prepare and send out. The process will benefit everybody in helping to reduce the costs of health care and allowing us to continue to provide exceptional service, which in the end benefits the community and patients we serve.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination. Co-payments are due at the time of the visit.

If you have any questions about this payment policy do not hesitate to contact us and speak to the Office Manager (Michele Marichal).

Sincerely yours,

Susan Manella, D.O.

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Patient's Financial Responsibility & Assignment of Insurance Benefits

1. My insurance policy is an agreement with my insurance company.

2. It is my responsibility to understand the benefits available to me through my insurance policy. The office of Manella Family Practice, LLC will, from time to time, contact my insurance company to inquire as to what benefits are available through my insurance plan. The office will make its best efforts to answer any questions about my benefits but this is not a guarantee that my insurance company will actually pay for those medical services.

3. I understand that my insurance company does not certify or guarantee any benefits until a clean claim is filed. Whether the office or I obtain information about my benefits, this is not a guarantee of payment. The office will advise me what benefits my insurance company has verbally stated are available to me. I realize that the choice to receive medical services at the office is entirely up to me. By providing these services to me the office is not accepting responsibility for their cost in the event my insurance company later claims that these services are not covered by my policy. I understand that the office, by accepting this assignment of insurance benefits will work diligently on my behalf to collect all benefits that are available through my policy. I agree to pay for services provided at my request or recommended by the office that my policy does not pay for.

4. Payment of Claims: I agree to respond promptly to any request for information from my insurance company or from the office in order to pay claims submitted by the office on my behalf. I understand that I will be billed for the services rendered after forty-five (45) days in the event that my insurance company refuses payment, pending information from anyone other than this office.

5. Payment for Services: Payment for services is expected at the time they are rendered unless I have signed a "Credit Card Authorization". Manella Family Practice, LLC will collect the following payments at the time of my visit in addition to accepting these assignments:

    - **Co-payments for services as determined by my policy**
    - **Unmet annual deductible amounts**
    - **Unpaid previous balances**

Occasionally, when there is uncertainty about whether a particular benefit will be covered, Manella Family Practice, LLC will collect the cost of the services at the time of the visit and place this amount on account. If my insurance company pays the services, Manella Family Practice, LLC will refund the amount paid, usually within thirty (30) days after receiving payment from insurer.

The charges that will be applied towards my credit card on file are: co-insurance, uncollected deductibles or copayments applied by my insurance carrier, non-covered charges after final determination from my insurance carrier, and any missed appointment fees. These charges will be charged to my credit card on file when Manella Family Practice, LLC receives reimbursement from my insurance carrier. An invoice or statement will be sent to me with a credit card receipt attached for my records.

6. Change in Insurance: It is my responsibility to notify Manella Family Practice, LLC of any change in my insurance policy, preferably at the time of scheduling an appointment. Most insurance companies have time limits for filing claims. In the event that the office is unable to collect for services rendered to me because they did not have current insurance information on file, these charges will be billed to me.

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7. Missed Appointment Fee: I understand that the office staff schedules a limited numbr of patients per hour which give me quality time with my provider. In the event I do not cancel or reschedule my appointment 24 hours prior to my appointment, I will be responsible for a $50.00 NO SHOW FEE, payable to Manella Family Practice, LLC. An authorization for credit card charge is required to be signed and filed with Manella Family Practice, LLC.

8. Delinquent Accounts: In the event my account should become seriously delinquent, I acknowledge that the office uses a collection agency to pursue delinquent accounts. I agree to be liable for any costs associated with the collection of my account if delinquent.

9. Patient's Individual Rights: I have the right to review or obtain a copy of my personal health information at any time. I have the right to request that Manella Family Practice, LLC correct any inaccurate or incomplete information in my records. I also have the right to request a list of instances where Manella Family Practice, LLC has disclosed my personal health information for reasons other than treatment, payment or other related administrative purposes. I may also request, in writing, that Manella Family Practice, LLC not use or disclose my personal health information for treatment, payment, and administrative purposes except when specifically authorized by me, when required by law or in emergency circumstances. Manella Family Practice, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

10. Medical Records Fee: There is a charge per page for any medical records requested. The charge will be waived if Manella Family Practice, LLC sends my records directly to the provider of my choice and a medical records release form is on file and signed by me. Manella Family Practice, LLC will not release any records unless I have signed a medical records release form.

I have read the foregoing and understand my obligation as outlined in this document. I have spoken with the office staff regarding any uncertainties I have and hereby request Manella Family Practice, LLC to continue my care. I hereby assign all benefits payable under my insurance plan to Manella Family Practice, LLC.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient or Responsible Party

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Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this Payment Policy. Please read it, ask us any questions you may have, and sign in the space provided.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you are insured by a plan with which we participate but do not have an up to date insurance card, payment in full for each visit is required until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Credit Card.** You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance company has paid their portion and notified us of the amount of your share. At that time any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.
3. **Co-Payment and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
4. **Non-Covered Services.** Please be aware that some, and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.
5. **Proof of Insurance.** All patients must complete our Patient Information Form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card (front and back) to ensure proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of a claim.
6. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in forty-five (45) days, the balance will automatically be billed to you.
8. **Missed Appointments.** Our policy is to charge $50.00 for missed appointments not cancelled 24 hours prior to your appointment. These charges will be your responsibility and billed directly to the credit card on file. An authorization for credit card charge is required to be signed and filed with Manella Family Practice, LLC. Please help us to serve you better by keeping your regularly scheduled appointments.

We are committed to providing the best care and service to our patients. Our prices are representative of the customary charges for our area.

Thank you for understanding the Payment Policy. Please let us know if you have any questions.

I have read and understand the Payment Policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient or Responsible Party

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MODIFICATIONS ARE NOT ALLOWED ON THIS DOCUMENT

Credit Card Authorization and Release of Related Medical Records

I hereby assign, transfer, and set over to Manella Family Practice, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. By submitting this signed and dated form, I fully acknowledge that I am the cardholder and hereby authorize Manella Family Practice, LLC to charge the credit card referenced below and apply any charges I am responsible for. This authorization shall remain until written notice is given by me revoking said authorization.

Credit Card Required on File: Visa_____ MasterCard_____ Amex _____

Credit Card # _____ Expiration Date: _____ CVV: _____

_____ _____

Cardholder Signature Date

_____

Print Cardholder Name

WE WILL NOT PROCESS FORMS

WITHOUT COMPLETE INFORMATION AND SIGNATURES

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HEALTH HISTORY QUESTIONNAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.)	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Vaccine	**Year of Last**	**Test / Exam**	**Year of Last**	**Test / Exam**	**Year of Last**
Tetanus	_____	Rectal / Stool	_____	Echocardiogram	_____
Flu	_____	Cholesterol	_____	Stress Test	_____
Pneumonia	_____	Tuberculosis	_____	CXR	_____
MMR	_____	Mammogram	_____	Pap Test	_____
Hepatitis B	_____	Prostate Exam	_____	Bone Density	_____

List any medical problem that other doctors have diagnosed:

	Yes	No		Yes	No		Yes	No
Hypertension			Heart Disease			Hyperlipidemia		
Diabetes			Lung Disease			Cancer		
Coronary Artery Disease			Depression			GERD		
Thyroid Disease			Anxiety			Kidney Disease		
Migraines			Arthritis			Osteoporosis		

Surgeries:

Year	Reason	Hospital

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HEALTH HISTORY QUESTIONNAIRE

Other Hospitalizations:		
Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

Pharmacy Name: _____ Phone #: _____ Fax #: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Name of Drug	Strength	Frequency Taken

Drug Allergies & Reactions: _____

_____

_____

Are you allergic to:

Food	☐ Yes	☐ No	Peanuts	☐ Yes	☐ No
Iodine	☐ Yes	☐ No	Pollen	☐ Yes	☐ No
Adhesive Tape	☐ Yes	☐ No	Animal Dander	☐ Yes	☐ No
Shellfish	☐ Yes	☐ No	Latex	☐ Yes	☐ No

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HEALTH HABITS & PERSONAL SAFETY

All questions in this questionnaire are optional and will be kept strictly confidential.

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting? ☐ Yes ☐ No			
	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No			
	# of meals you eat in an average day			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups / cans per day			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	☐ Cigarettes - pks / day	☐ Chew - # / day	☐ Pipe - # / day	☐ Cigars - # /day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	If yes, please list:			
	Have you ever given yourself street drugs with a needle?			☐ Yes ☐ No
Sex	Are you sexually active?			☐ Yes ☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with the provider about risk of this illness?			☐ Yes ☐ No
Personal Safety	Do you live alone?			☐ Yes ☐ No
	Do you have frequent falls?			☐ Yes ☐ No
	Do you have vision or hearing loss?			☐ Yes ☐ No
	Physical and/or mental abuse has become a major health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes ☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	☐ M ☐ F	
				☐ M ☐ F	
Mother				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Grandmother Maternal		
	☐ M ☐ F		Grandfather Maternal		
	☐ M ☐ F		Grandmother Paternal		
	☐ M ☐ F		Grandfather Paternal		

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HEALTH HABITS & PERSONAL SAFETY

Mental Health	
Is stress a problem for you?	☐ Yes ☐ No
Do you feel depressed?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No
Have you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No

Women Only	
Age at onset of menstruation	
Date of last menstruation	
Period every _____ days	
Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within a year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No

Men Only	
Do you usually get up to urinate during the night?	☐ Yes ☐ No
If yes, # of times	
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning discharge from your penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erections or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No

Other Problems

Check if you have, or had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest / Heart	Recent changes in:
☐ Head / Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	
☐ Lungs	☐ Circulation	

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RECORD RELEASE AUTHORIZATION

To: _____

_____

_____

I hereby authorize and request the release of copies of the following information:

_____ Complete Medical Record _____ X-Rays _____ Laboratory

_____ Procedure Reports Other: _____

(Including current an previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records.)

TO:

Manella Health & Wellness, P.A.
Manella Family Practice, LLC
500 N. Hiatus Rd., Suite 201
Pembroke Pines, FL 33026
Phone (954) 381-8989 Fax (954) 381-8950

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

_____ Single Disclosure _____ Continuing Disclosure for 120 days. Expiration date: _____

I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.
Note: There is a fee of $1.00 per page for the first 20 pages and 35 cents per page thereafter.

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NOTICE
LABORATORY BILLING INFORMATION

We are providing In House Lab Draw as a convenience to our patients.
Effective January 1st of 2014 the lab draw fee will be $25.00.

The fee only applies if labs are not drawn at the time of your office visit.
Please be advised that lab tests ordered by your physician may NOT be covered by your insurance carrier. Laboratory testing services may require some out-of-pocket expenses for deductibles, co-pays, co-insurance and non-covered services. We cannot guarantee reimbursement from your insurance carrier and we are not responsible for any testing that is not covered by your insurance carrier. You may receive a bill from the lab directly (Quest, LabCorp) for any balance that your insurance carrier did not cover.

_____ **Option 1. YES.** I want to receive these services.

_____ **Option 2. NO.** I have decided not to receive these services.

_____ _____
Date **Signature of patient or person acting on patient's behalf**

Regarding Test Results

Effective January 1, 2014 results for all testing will no longer be given via phone. Upon leaving the office, please make sure to schedule a follow up appointment to review your test results with a provider.

NO SHOW NOTICE

Effective as of May 3, 2018 there will be a no show charge of $50 for any appointment that is missed or any appointment that is not cancelled with 24 hour notice.

Patient Name: _____

Patient / Guardian Signature: _____

Thank you for your cooperation.

Management ☺

Revised 4/10/19

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons / organizations providing the information:	**Persons / organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ____ / ____ / ____ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

Notice of Privacy Acknowledgement

Manella Family Practice, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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500 N. Hiatus Rd., Suite 201
Pembroke Pines, FL 33026
(954) 381-8989

Effective 1/1/2014

We have given you all the tools in order to make your necessary appointments.

If you need any help scheduling your appointments, please feel free to call or email me for assistance.

Due to a high volume of referral requests, please allow 3 to 4 business days for referrals to be processed. We will no longer issue same day referrals. I work on referrals Monday & Friday afternoons.

If there is a need for urgency, please contact me directly and I will be happy to help in any way that I can. My contact information is below; please allow 24 hours for an email response.

If I have not responded to your email within 24 hours, please call the office and ask to speak with me directly.

As Always . . . Best Wishes for your Health,

Nicole Cabassa
Referral Coordinator

Email: ncabassa@femwell.net
Phone: 954-381-8989

Print Name: _____

Sign Name: _____

Date: _____

Revised 4/10/2019

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E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but are not limited to, the following risks:

a. E-mails can be circulated, forwarded, and stored in numerous paper and electronic files.

b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.

c. E-mail senders can easily type in the wrong e-mail address.

d. E-mail is easier to falsify than handwritten or signed documents.

e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.

f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into the computer system,

i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.

b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

E-mail Consent Form

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing, and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP:

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

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E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have / had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____