Gregory F. Piro, D.O., P.C.
Dermatology and Dermatologic Surgery

MEDICAL INFORMATION

Please answer all questions by circling the right answer below.

CONCERNING ALLERGIES
DO YOU HAVE AN ALLERGY TO:
Medications or drugs____________________________
Ointments, Creams or lotions Yes No
Make-up or jewelry Yes No
Insect bites Yes No
Other: Yes No
____

DO YOU OR ANYONE IN YOUR FAMILY SUFFER FROM:
Hayfever Yes No
Asthma Yes No
Sinus problems Yes No
(If yes, specify who has it).
____

CONCERNING THE HEART AND VASCULAR SYSTEM
DO YOU HAVE A HISTORY OF:
Heart disease Yes No
Blood pressure problems Yes No
Abnormal heart beat Yes No
Heart pacemaker Yes No
Heart Murmurs Yes No
Rheumatic valve disease Yes No

CONCERNING YOUR LUNGS
DO YOU HAVE A HISTORY OF:
Bronchitis Yes No
Emphysema Yes No

CONCERNING YOUR INTERNAL ORGANS
DO YOU HAVE A HISTORY OF:
Stomach ulcers Yes No
Bowel disease Yes No
Liver disease Yes No
Diabetes Yes No
Kidney disease Yes No
Bladder infections Yes No
Vaginal infections Yes No
Prostatic disease or infections Yes No
Thyroid disease Yes No
Venereal disease Yes No

CONCERNING YOUR NERVES
DO YOU HAVE A HISTORY OF:
Seizures Yes No
Migraine headaches Yes No
Depression Yes No
Others: Yes No
____

CONCERNING YOUR BLOOD
DO YOU HAVE A HISTORY OF:
Anemia Yes No
Bleeding problems Yes No
Sickle cell disease Yes No

CONCERNING YOUR SKIN
DO YOU HAVE A HISTORY OF:
Skin Cancer Yes No
Lupus Yes No
Dermatomyositis Yes No
Connective tissue disease Yes No
Other skin Diseases Yes No
(If yes, please list below)
____
____

CONCERNING YOUR FAMILY
HAS ANYONE IN YOUR FAMILY HAD:
Heart Disease Yes No
Diabetes Yes No
Skin cancer Yes No
Other cancers: Yes No
____
____

CONCERNING YOUR SOCIAL ACTIVITIES
DO YOU DRINK ALCOHOLIC BEVERAGES? Yes No
(If yes, how many drinks a day?)
____
Do you smoke? Yes No
(If yes, how much?)
____

Please list the name of any medication you are currently taking (including vitamins and birth control pills).
____
____
____
____
____

Please list the name and approximate date of any operation you have had.
____
____
____
____

Date of: Illness (first symptom), or Injury (accident), or pregnancy (LMP)
____

_____________________ _____________________ _____________________
PRINT NAME SIGNATURE DATE

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1155 Byron Rd.
Howell, MI 48843
Phone: (517) 545-2300
Fax: (517) 545-2880

7575 Grand River
Brighton, MI 48114
Phone: (810) 227-8500
Fax: (810) 844-7567

If you are enrolled in a HMO healthcare plan

Please take a moment to read the following.

A **HMO** type healthcare plan requires a referral authorization from your Primary Care Physician for insurance payment of the services provided. The referral is very importance because it includes information including:

1) Specific diagnosis or problem that is to be evaluated.
2) Authorization for surgery or procedures.
3) Number of visits.
4) Expiration date.

If you:

1) Do not have a referral.
2) Have referral that is expired.
3) Would like a problem addressed that is not on your referral.

We can:

*reschedule your appointment at a later date after you obtain the proper referral authorization.

*Provide the service and have you be responsible for payment of the fees. Please realize that you will not get this payment reimbursed later by your health insurance plan.

We will be happy to answer any questions at the front desk.

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Patient Information

Date______ Account Number (office use only) ______ Patient's Social Security #____________________

Patients Last Name_______________________ First Name ________________ Init ________ Sex M F

Date of Birth_________ Patient Phone#/ Cell#_______________ Employer__________________________

Marital Status: Single Married Divorced Widowed

Relationship to the insured: 1=Self 2=Spouse 3=Dependent

Address_______________________________City_____________________State_______Zip__________

Homephone____________________Employer_______________________Work Phone______________

Name of Party Responsible for Payment (Don't fill out if same as above)

Last Name_______________________________ First Name________________________ Init_________

Address________________________________ City____________________ State______Zip__________

Homephone_____________________Employer______________________Work Phone______________

Primary Care Physician

Name of Provider____

Address________________________________City_____________________State_______Zip_________

Office Phone________________________

Emergency Contact

Name____Relationship___________________

Address_______________________________City______________________State________Zip________

Phone______________________________

Who referred you to our office? / How did you hear about us? __________________________________

Please give your insurance cards to the receptionists so that they may photocopy them.

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About Financial Arrangements

We are committed to providing you with the best possible care. If you have a medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

All of our billing to insurance companies and patients is performed by Medical Data Management Corporation. If you have any billing questions please call (800) 320-2749.

Payment for services is due at the time services are rendered unless we are aware you have insurance coverage for this particular visit. It is the patients/ subscriber's responsibility to submit claims covered under any Master/ major medical policy, unless prior arrangements have been made with the office staff. Returned checks and balances older than 30 days may be subject to additional collection fees.

By signing this document, I agree in order for Gregory Piro D.O. to service my account or to collect any amounts I may owe, Gregory Piro D.O. and its third party billing and/ or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using prerecorded/ artificial voice messages and / or use of an automatic dialing device, if applicable.

I/ We have read this disclosure and authorize express consent that Gregory Piro D.O. its affiliates, and third party services providers may contact me/ us as described above.

____
Patient Signature & Date

We participate with various insurance plans, accepting assignment of benefits. Please check with your insurance company to verify that Dr. Piro is a participating physician. Co-pays and deductibles remain your responsibility. It is the responsibility of the patient / subscriber to obtain any necessary referral forms or authorization numbers. If you fail to obtain these necessary forms / numbers, you will be held responsible for your balance.

We are happy to process other insurance plans. You must realize, however, that:
Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract
Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of the U.C.R.. U.C.R. is defined as Usual, Customary and Reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "Schedule of Fees" which bears no relationship to the current standard and cost of care in this area.
Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company, While the filing of insurance claims is a courtesy that we extend to our patients, all charges are you responsibility from the date services are rendered.

I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all of the information on both sides of this sheet and have completed the necessary information. I hereby instruct and direct my insurance company to pay by check made out to Dr. Gregory Piro, D.O., P.C. the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is information pertinent to my case to any insurance company or adjuster involved in this case. I certify this information is true and correct to the best of my knowledge.

SIGNATURE___________________________________ DATE___________________

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Marketing Health-Related Services: We will not use your health information for marketing communication without your written consent.
Required By Law: We may use or disclose your health information without your consent or authorization in certain situations. These Situations include: Required By Law; Public Health; Communicable Disease; Health Oversight;; Abuse or Neglect; Food and Drug Administration; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military or National Security; Workers' Compensation; Inmates; Required Uses and Disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
Appointment Reminders: we may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, letters).
Patient Rights
Following is a statement of your rights with respect to your protected health information.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or preceding; and protected health information that is subject to law that prohibits access to protected health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information, for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and must state the specific restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make this request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively; i.e., electronically.

Complaints: you may complain to us or the Secretary 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 our privacy contact of your complaint. We will not retaliate against your filing a complaint.

Acknowledgement:
I acknowledge that I have received the attached Notice of Privacy Practices.

____ ______________________

Patient or Personal Representative Signature Date
If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

I Give________________________________ ______________________________Permission to receive any information
(Name) (Relationship)
Regarding my medical records or appointments.

Initials: ________________

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NOTICE OF PRIVACY PRACTICES FOR

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.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04-13-03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

The Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health care information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for the hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training programs, accreditation, certification, licensing or credentialing activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, You may revoke it in writing at any time. Your revocation will not affect any use or disclose your health information for any reason except those described in this notice.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the persons' involvement in your healthcare. We will also use our professional judgment and our experience with common or other similar forms of health information.

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Dear Patient,

We are continuously working on ways to improve how we provide care to you and will work closely with your Primary Care Physician in meeting your needs. We are asking you to improve your health care experience by taking an active role in your health care. We will be asking you to identify your goals and the outcomes you wish to achieve with your visits to our office.

WE TRUST YOU, AS OUR PATIENT TO:

- Tell us what you know about your health and illnesses and what your needs and concerns are.
- Take an active part in planning your care and following that plan. Inform us if you are unable to meet your goals.
- Tell us what medications you are taking and to take your prescribed medications as directed. To ask for refills in a timely manner so there are no lapses in medication dosing. Ask for your refills at the time of your office visit.
- Keep us informed when you see other doctors and what medications they prescribe for you if changes have been made.
- Learn about wellness and prevention: seek our advice before seeing other physicians.
- Keep your appointments and to know your insurance and what it covers. We expect you to pay your share of the visits when seen in the office.

WE, AS YOUR PHYSICIAN WILL:

- Provide care according to the goals you have established with your primary care physician.
- We will communicate regularly with your primary care physician to coordinate your care.
- Provide safe, quality care to you when needed, with respect to you and your privacy. We will not share your medical information without your permission.
- Help you plan goals that meet your needs and discuss these goals with you to improve your health and help prevent persistent health problems.
- Discuss the most appropriate tests and procedures you need to meet your goals and help coordinate your care among other health care professionals.
- Tell you about your health and illness in a way you can understand and provide care for short or long-term illness and give advice to help you stay healthy.

If you have any questions/ concerns about Dermatology treatment today, please let us know. If you have any questions/ concerns about other health issues or medications, please contact your PCP.

We are pleased you have chosen us to be a part of your health care team. Coordination of your care and communications with your PCP is our priority.
If you wish to seek immediate care after office hours, please proceed to your nearest urgent care facility. Following is a few of Urgent

Care Facilities located near our offices:

IHA Urgent Care – 10020 Professional Center Dr., Hamburg- (810) 231-6080, open until 9:00pm
Livingston Urgent Care- 1225 S. Latson Rd, Howell – (517) 338-2360
IHA After Hours – 2305 Genoa Business Park Dr., Brighton – (810)494-6810, opens at 5:00pm
IHA Urgent Care, West Arbor- 3450 Jackson Rd, Ann Arbor _ (734)887-4396, 8:00am-10:00pm

If you're experiencing a LIFE-THREATENING emergency, please proceed to the nearest Emergency Room.

Sincerely,
Dr. Gregory F. Piro, D.O.

Acknowledgement

I acknowledge that I have received the attached Notice.

_______________________________ Name

_______________________________ Date