Jeffrey A. London, MD, PC
Birmingham Maple Clinic

Case #: ______________
Dx: ________________

Identifying Data

Date Seen: ______________

Name:
Address:
City, State, Zip:
Telephone: Home: ( ) Work: ( ) Cell: ( ) Email: You have my permission to contact me by email Yes ☐ No ☐
Employer:
Employer Address:
City, State, Zip:
School:
Person responsible for payment if other than patient: Telephone: Name: ______________ Home: ______________ Address: ______________ Work: ______________ ______________ Cell: ______________
Insurance Information: Primary Insurance Co:
Group#: Insured's SS#: Insured's Birthdate:
Insured's Name: Relationship:
Insurance Co. Phone:
Secondary Insurance Co.:
Group#: Insured's SS#: Insured's Birthdate:
Insured's Name: Relationship:
Insurance Co. Address:
Insurance Co. Phone:
Private Pay:

JEFFREY A. LONDON, MD, PC
FINANCIAL POLICY

As a patient of Dr. London, it is important for you to understand the following information:

- You are responsible for the timely payment of your account. Your co-pay amount should be paid at each session.

- We accept cash, check, Visa and Mastercard.

- Payment should be made by the parent/guardian who brings their child to the appointment. We will not become involved in disputes between individuals. It is your responsibility to assure that we receive payment for the services rendered. After the 1st visit, co-payments should be made at the time of each appointment.

- Missed Appointments:

  My staff will try to call to remind you prior to each appointment. Unless canceled 24 hours in advance, my policy is to charge for missed appointments. Keep in mind that insurance companies will not cover this cost. Please help us serve your better by keeping all scheduled appointments..

- Regarding Insurance:

  We will verify your insurance following the first visit. Verification of coverage does not guarantee payment. Insurance is a contract between you and your insurance company. We **cannot** be a party to this contract. In most cases, we file insurance claims as a courtesy to our clients. Although we will supply factual information to your insurance company when necessary, we will not become involved in disputes between you and the company regarding deductibles, co-payments, covered charges, in disputes between you and the company regarding deductibles, co-payments , covered charges, secondary insurance coverage, usual and customary charges, etc. In the event that third party payment is denied after the service has been provided, you will still be help responsible for the cost of that service.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL AND INSURANCE POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONVERNS.

______________________________ ______________________________

Client, Parent or Guardian (if under 18) Date Witness Date

____

Social Security Number

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN CLIENT:

Name: ______________________________ Telephone: ____________

Address: ______________________________

Employer: ______________________________ Telephone: ____________

Employer's Address: ____

Signature of Responsible Party: ____________________________________

JEFFREY A. LONDON, MD, PC

INFORMED CONSENT

My treatment plan has been reviewed with me and I have had the opportunity to discuss any questions with Dr. London.

Client, Parent or Guardian	Witness
Date	Date

JEFFREY A. LONDON, MD, PC

STATEMENT OF FINANCIAL RESPONSIBILITY

I assume financial responsibility for all scheduled appointments attended and for those not attended unless cancellation is made prior to twenty-four hours of the scheduled appointment time.

Client, Parent or Guardian	Witness
Date	Date

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AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to the provider of the Benefits, if any, otherwise payable to me for the services rendered. I understand the provider's charge may exceed the private insurance carrier payment. If the charge is greater than such payment, I will be responsible for that amount. I hereby authorize the provider to release any information required in order to obtain these Benefits.

Client, Parent or Guardian	Witness
Date	Date

JEFFREY A. LONDON, MD, PC

HEALTH INFORMATION

Name of Client ______________________ **BD** ________ **Date.** ________

DATE OF LAST PHYSICAL EXAMINATION: ____________ NAME OF PHYSICIAN: ______________

REVIEW OF SYSTEMS:

Have you ever experienced difficulty in any of the following areas:

1. Central Nervous System (Headaches, dizzy spells, sleep disturbance, etc.) No ☐ Yes ☐

If Yes, please explain: ____

____

2. Cardiovascular / Respiratory System No ☐ Yes ☐

If Yes, please explain: ____

____

3. Digestive System (Ulcers, ileitis. etc.) No ☐ Yes ☐

If Yes, please explain: ____

____

4. Genitourinary System No ☐ Yes ☐

If Yes, please explain: ____

____

5. Musculoskeletal System No ☐ Yes ☐

If Yes, please explain: ____

____

6. Endocrine System (Diabetes, etc.) No ☐ Yes ☐

If Yes, please explain: ____

____

7. Immunological System (Lupus, etc.) No ☐ Yes ☐

If Yes, please explain: ____

____

GENERAL MEDICAL HISTORY:

1. Have you ever been hospitalized or had surgery? No ☐ Yes ☐

If Yes, please explain: ____

____

Continued on reverse side

2. Have you ever a serious accident or injury? No ☐ Yes ☐

If Yes, please explain: ______________________________

____

3. Have you ever had nutritional problems? No ☐ Yes ☐

If Yes, please explain: ______________________________

____

4. Have you ever had previous psychotherapy or counseling? No ☐ Yes ☐

If Yes, please explain: ______________________________

____

5. Have you ever had problems with alcohol or drugs? No ☐ Yes ☐

If Yes, please explain: ______________________________

____

MEDICATIONS:

List current medications (including seizure related medications) and reason for taking

____

____

____

ALLERGIES:

Include allergies to medications

____

____

____

FAMILY HISTORY:

If any blood relative has suffered any of the following, please check the appropriate box and indicate which relative.

☐ Heart Attack ______________

☐ Stroke ______________

☐ Cancer ______________

☐ Diabetes ______________

☐ Epilepsy ______________

☐ Lung Disease ______________

☐ Arthritis ______________

☐ Glaucoma ______________

☐ Hypertension ______________

☐ Allergies ______________

☐ Alcohol / Drug Problems ______________

☐ Mental / Emotional Problems ______________

****

Name of Physician ______________________________

Name of relative or responsible party we may contact in case of an emergency

______________________________ ______________

Name Relationship

______________________________ ______________

Address Telephone

BIRMINGHAM MAPLE CLINIC

JOINT NOTICE OF PRIVACY PRACTICES

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.

Effective Date: September 11, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or otherwise maintained by Birmingham Maple Clinic. Your other non-Birmingham Maple Clinic doctor may have different policies or notices regarding that health care provider's use and disclosure of your medical information created in a non-Birmingham Maple Clinic office or clinic.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Maintain the privacy of your medical information that identifies you;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

This Notice will cover Birmingham Maple Clinic and those medical providers, who, while not necessarily legally affiliated with us, may provide you with care or treatment at Birmingham Maple Clinic. Together, Birmingham Maple Clinic and these medical providers are part of the "Birmingham Maple Clinic Organized Health Care Arrangement" (referred to as an "OHCA"). This Notice describes privacy practices of those participating in the Birmingham Maple Clinic OHCA. This Notice covers:

- Any health care professional authorized to enter information into any medical record established and maintained by Birmingham Maple Clinic.
- All departments and units of Birmingham Maple Clinic.
- All employees, staff, volunteers and other Birmingham Maple Clinic personnel.
- The individual health care providers of Birmingham Maple Clinic.
- Bradley S. Klein, D.O., P.L.C.
- Jeffrey A. London, M.D., P.C.

In addition, Birmingham Maple Clinic and the Birmingham Maple Clinic OHCA may share your medical information with each other for treatment, payment or health care operations purposes described in this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. For each category we explain what we mean and give some examples. Our records contain information regarding your mental health or may contain information on substance abuse; those records may be subject to additional restrictions, which we will comply with, under state law. Also, if you are a minor, certain specific information that relates to mental health, substance abuse, pregnancy or sexually transmitted diseases, may be protected by additional restrictions under state law, which we will comply with. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use health information about you to provide you with treatment, health care or other related services. We may disclose your health information to doctors, nurses, aids, technicians or other employees who are involved in taking care of you. Additionally, we may use or disclose your health information to manage or coordinate your treatment, health care or other related services. For example: The therapist or psychiatrist treating you may need to know if you have an illness or disease or are currently taking prescription medication for the treatment of an illness or disease, because this may affect the type of therapy you are provided and your recovery. In addition, we may need to tell another healthcare provider this information so that we can arrange for appropriate care for you. We also may need to disclose information about you to people outside Birmingham Maple Clinic who may be involved in your care, such as, family members.

- **For Payment**. We may use and disclose your health information to bill and collect for the treatment and services we provide to you. We may send your health information to an insurance company or other third party for the payment purposes including to a collection service. We may also disclose your health information to another health care provider or payor of health care for the payment activities of that entity. For example: We may give your health plan or insurance company information about a treatment or service you have received, or are going to receive so that we can be reimbursed for providing that treatment or service. We may also contact your health plan or insurance company for prior treatment authorizations and referrals.

- **For Health Care Operations**. We may use and disclose your health information for health care operations. These uses and disclosures are necessary to run Birmingham Maple Clinic, to make sure you receive competent, quality health care, and to maintain and improve the quality of health care we provide. We may also provide your health information to various governmental or accreditation entities to maintain our license and accreditation. For example: We may use your health information to:
  - Evaluate the performance of our staff in caring for you;
  - Assess the quality of care and outcomes in your case(s) and similar cases compared against other therapists and psychiatrists in the area, state, or nation;
  - Learn how to improve our facilities and the services we provide; or
  - Determine how to continually improve the quality and effectiveness of the health care we provide.

- **Incidental Uses and Disclosures.** We may occasionally inadvertently use or disclose your health information when such use or disclosure is incident to another use or disclosure that is permitted or required by law. For example: While we have safeguards in place to protect against others overhearing our conversations that take place between therapists, psychiatrists or other personnel, there may be times that such conversations are in fact overheard. Please be assured, however, that as much as possible, we have appropriate safeguards in place in an effort to avoid such situations.

- **Disclosures to You**. Upon a request by you, we may use or disclose your health information in accordance with your request.

- **Limited Data Sets**. We may use or disclose certain parts of your health information, called a "limited data set," for purposes of research, public health reasons or for our health care operations. We would disclose a limited data set only to third parties that have provided us with satisfactory assurances that they will use or disclose your health information only for limited purposes.

- **Disclosures to the Secretary of Health and Human Services.** We might be required by law to disclose your health information to the Secretary of the Department of Health and Human Services, or his/her designee, in the case of a compliance review to determine whether we are complying with privacy laws.

- **De-Identified Information.** We may use your health information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law.

- **Disclosures by Members of Our Workforce.** Members of our workforce, including employees, volunteers, trainees or independent contractors, may disclose your health information to a health oversight agency, public health authority, health care accreditation organization or attorney hired by the workforce member, to report the workforce member's belief that we have engaged in unlawful conduct or that our care or services could endanger a patient, workers or the public. In addition, if a workforce member is a crime victim, the member may disclose your health information to a law enforcement official.

- **For Public Health Purposes.** We may disclose health information about you for public health activities. These activities may include the following:
  - To prevent or control disease, injury or disability;
  - To report reactions to medications or problems with products; or
  - To avert a serious threat to health or safety. Any disclosure, however, would only be to someone able to help prevent or lessen the threat or to law enforcement authorities in particular circumstances.

- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws.

- **About Victims of Abuse.** We may disclose your health information to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **As Required By Law.** We will disclose your health information when required to do so by federal, state or local law or regulation.

- **Judicial Purposes.** We may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process issued by a Court.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official, if such disclosure is:

  - Required by law;
  - In response to a Court issued; Order, Subpoena, Warrant, Summons or similar process;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About criminal conduct at Birmingham Maple Clinic; or
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime, a suspect, fugitive, material witness, or missing person.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, only if you have agreed in writing to such a release, except that your consent will not be required if the information disclosure has been ordered by a court of law.

- **Coroners, Medical Examiners and Funeral Directors**. In certain circumstances, we may disclose health information to a coroner or medical examiner. This may be necessary, For example, to identify a deceased person or determine the cause of death. We may also release health information about individuals to funeral directors as necessary to carry out their duties.

- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all individuals who received one medication or treatment to those who received another. All research projects, however, are subject to a special approval process. This process includes evaluating a proposed research project and its use of health information, trying to balance the research needs with your need for privacy of your health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. Additionally, when it is necessary for research purposes and so long as the health information does not leave Birmingham Maple Clinic, we may disclose your health information to researchers preparing to conduct a research project, For example, to help the researchers look for individuals with specific health needs. Lastly, if certain criteria are met, we may disclose your health information to researchers after your death when it is necessary for research purposes.

- **Military and Veterans**. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may disclose your health information as authorized by and to the extent necessary to comply with workers' compensation laws or laws relating to similar programs.

- **Communications Regarding Our Services or Products.** We may use and disclose your health information to make a communication to you to describe a health-related product or service of Birmingham Maple Clinic In addition, we may use or disclose your health information to tell you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, providers or settings of care for you. We may occasionally tell you about another company's products or services, but will use or disclose your health information for such communications only if they occur in person with you. We may also use and disclose your health information to give you a promotional gift from us that is a minimal value.

- **Treatment Alternatives, Appointment Reminders and Health-Related Benefits**. We may use and disclose your health information to tell you about or recommend possible treatment alternatives or health-related benefits or services that may be of interest to you. Additionally, we may use and disclose your health information to contact you by mail or phone to provide appointment reminders. If you do not wish us to contact you about treatment alternatives, health-related benefits or appointment reminders, you must notify us in writing, and state which of those activities you wish to be excluded from

- **Individuals Involved in Your Care or Payment for Your Care**. We may release health information about you to a family member, other relative, or any other person identified by you who is involved in your health care. We may also give information to someone who is involved with or helps pay for your care. We may also tell your family, friends, personal representative or other person responsible for your health care your condition and that you are at the Hospital.

- **Third Parties.** We may disclose your health information to third parties with whom we contract to perform services on our behalf. If we disclose your information to these entities, we will have a written agreement with them to safeguard your information.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization.

You understand that we are unable to take back any disclosures we have already made under the authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example: You could ask that we not use or disclose information about your condition to a certain person to whom disclosure would otherwise be permitted. Also, we will honor a valid Court Order that you provide to us, which restricts disclosure of information about a child to a non-custodial parent.

  We will comply with your request unless the information is needed to provide you emergency treatment, is required by law or a third party payment contract.

  To request restrictions, you must make your request in writing and submit it to the individual at the address identified at the end of this Notice. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you or your responsible party about your health care in an alternative way or at a certain location.

  To request confidential communications, you must make your request in writing and submit it to the individual at the address identified at the end of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Inspect and Copy**. You have the right to inspect and copy health information that may be used to make decisions about your care.

  To inspect and copy health information that may be used to make decisions about you, you can submit your request in writing to the individual at the address identified at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend**. You have the right to ask us to amend your health and/or billing information for as long as the information is kept by us.

  To request an amendment, your request must be made in writing and submitted to the individual at the address identified at the end of this Notice. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for us;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - We believe is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures that we have made of your health information.

  To request this list of disclosures, you must submit your request in writing and submit it to the individual at the address identified at the end of this Notice. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (*For example; on paper or electronically*). The first list you request within a twelve-month period will be free. For additional lists, during such twelve-month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

  To obtain a paper copy of this Notice, contact us in writing and submit it to the individual at the address identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in a clear and prominent location to which you have access. The Notice is also available to you upon request. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, if we revise the Notice, you may request a copy of the revised Notice then in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Birmingham Maple Clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Privacy Officer at the address listed at the end of this Notice. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

If you have any questions about this Notice, please contact:

Privacy Officer – Birmingham Maple Clinic, Inc.
950 E. Maple Road
Birmingham, Michigan 48009

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received Birmingham Maple Clinic's Notice of Privacy Practices ("Notice").

____________________________________ Date:__________________________

Signature (Patient or Authorized Representative)

____

Printed (Patient or Authorized Representative)