CLARK CHEN, D.O.
BIRMINGHAM MAPLE CLINIC

Date: ____________________

PATIENT INFORMATION FOR ADULTS:

Patient Name:	Date of Birth	SSN:
Address:		
City, State, Zip:		
Telephone: Home: ( )	Work: ( )	Cell: ( )
Email:	You may contact me by email	Yes ☐ No ☐
Employer:		
Employer Address:		
City, State, Zip:		
Person responsible for payment if other than patient: Name:____________________ Address:____________________ ____________________	Telephone: Home:____________________ Work:____________________ Cell: ____________________	
Subscriber Information: **Primary Insurance** :		
Group number:	Subscriber SS #:	Subscriber birthdate:
Subscriber Name:		Relationship:
Insurance Co. Phone:		
Secondary Insurance:		
Group #:	Subscriber SS#:	Subscriber birthdate:
Subscriber name:		Relationship:
Insurance Co. Address		
Insurance Co. Phone		
Private Pay:		

Patient Name: ____

What is your current gender identity:

□ Male □ Female
□ Transgender Male/ Transgender Man/ Female-to-Male (FTM)
□ Transgender Female/ Transgender Woman/ Male-to-Female (MTF)
□ Genderqueer – neither exclusively male nor female
□ Other ______________________________
□ Choose not to disclose

What pronouns do you prefer that we use when talking about you? (check all that apply)

□ She/her/hers
□ He/him/his
□ They/them/theirs
□ Other: Please specify: __________________________

Do you think of yourself as:

□ Straight or Heterosexual
□ Lesbian, Gay, or Homosexual
□ Bisexual
□ Something else
□ Don't know
□ Choose not to disclose

Please describe your current relationship status (check all that apply):

□ Single □ Married □ In a civil union □ In a domestic partnership, living together □ Partnered, not living together □ Divorced □ Widowed □ In a committed relationship □ Other: ________

Patient Name: ____

Primary care physician:

Name: ________________________________

Address: ____________________________ City: ____________
State__________Zip_________

Phone: _________________________Date of last physical exam: ____________

Referring Physician: ☐ Is my primary care physician

Name: ________________________________

Address: ____________________________ City: _____________
State__________Zip_________

Phone: _________________________

Emergency Contact Name:

____

Relationship to Patient:

____

Emergency Contact Phone Number:

____

PHARMACY

We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:

Local Pharmacy: ____________________ Phone Number: __________________

Address (or cross streets): __________________________ City: _____________

Mail Order Pharmacy: ____________________ Phone Number: _______________

Address: ________________City: ____________State: _______Zip code: ________

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ADULT HEALTH/BACKGROUND INFORMATION

Name ______________________________ DOB______________ Date______________
Assigned Sex: M F Choose not to Disclose Age: _______ Ethnic Background: __________
Religious Belief: _______________
Phone: __________________ Work: ____________________ Cell: ______________

ALLERGIES: ____

Current prescriptions and over the counter medications:

Current concerns;

Have you threatened or attempted to harm yourself or others □ Yes □ No If yes explain:

FAMILY INFORMATION:

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

□ Heart Attack__________________ □ Arthritis ________________________
□ Stroke ______________________ □ Glaucoma ________________________
□ Cancer ______________________ □ Hypertension ______________________
□ Diabetes _____________________ □ Allergies _________________________
□ Epilepsy _____________________ □ Alcohol/Drug problems ________________
□ Lung disease __________________ □ Mental / Emotional problems ____________

MEDICAL HISTORY:

Primary Care Physician: ______________________________ phone number: ____________
Date of last physical: ____
Recent weight gain? ______ Loss? ________ appetite change? _________
Please provide any information on any surgical procedures and/or hospitalizations: ____________

History of serious accident or injury? □No □Yes: ___________________________

History of nutritional problems? □ No □Yes:_________________________________

Substance use? □ No □ Yes If yes , describe: _______________________________
Substance abuse treatment □ No □ Yes If yes, explain_________________________

□ Tobacco □ Alcohol □ Marijuana □ Cocaine □ Heroin □ Pills □ Inhalants □ Synthetic Drugs
□ Hallucinogens □ Other ____________________

Check all that apply:

□ seizures	□ heart murmur	□ abnormal balance
□ headaches	□ fast heartbeat	□ tremor
□ injury to head	□ irregular heartbeat	□ dizziness
□ loss of consciousness	□ chest pain	□ fainting spells
□ vision changes	□ change in appetite	□ tics / twitching
□ hearing problems	□ weight change	□ muscle weakness
□ musculoskeletal problem	□ nausea/ vomiting	□ numbness/ tingling
□ sinus problems	□ jaundice/ hepatitis	□ rashes/ hives
□ nosebleeds	□ liver disease	□ sweating
□ abnormal sense of smell	□diabetes	□ bone fractures
□ sore mouth or tongue	□ abdominal pain	□ joint pain
□ dental problems	□ constipation/ diarrhea	□ cancer/ tumor
□ difficulty with speech	□ urinary infections	□ anemia
□ frequent sore throats	□ frequent urination	□ bleeding/ bruising
□ thyroid problems	□ blood in urine	□ chronic fatigue
□ breathing problems	□ kidney disease	□ frequent infections
□ shortness of breath	□ sexual problems	□ scarlet fever
□ Asthma/Wheezing	□ Gynecological problems	□ Measles/Rubella
□ Chronic cough	□ menstrual pain	□ encephalitis/ meningitis
□ pneumonia	□ pregnancy	□ herpes
□ heart disease	□ HIV/AIDS	□ Venereal disease
□ immune problems (lupus)	□ other	

____

____

DEVELOPMENTAL HISTORY:

Pregnancy/ Labor/ Delivery: □ Term □ Preterm Delivery
Complications at birth □ No □ Yes ____________________
Maternal postpartum depression: □ No □ Yes ____________________
Met developmental milestones on time □ No □Yes, if No describe any concerns ____________________
____
Behavioral problems as a child: ____________________
Language and reading skills: □ As expected □ Had/Having problems
Special education services □ No □ Yes :____________________
Repeated Grade: □ No □ Yes: ____________________

History of: □ Medical problems □School suspensions or expulsions □Sleep problems □ Police or legal problems □ Defiance / anger □Growth problems □ Running away □ School failure □Multiple school changes □ Friendship problems □ Family discord □ Divorce, illness / loss □Financial strains □ Physical or emotional trauma □ Sexual identity or preference concerns □ Self mutilation □ Bizarre behavior or ideas

History of abuse? □ No □ Yes
Has sex ever been forced? □ No □ Yes

Has there ever been a Protective Service case open ☐ No ☐ Yes
Legal problems? ☐ No ☐ Yes

MENTAL HEALTH HISTORY:

Previous counseling, therapy, or psychiatric treatment? ______________________
Has anyone in the family had any psychological or psychiatric problems? ☐ No ☐ Yes ________
____
Ever been admitted to a state or local psychiatric facility? ☐ No ☐ Yes ______________________

EDUCATION/WORK:

Highest grade completed: ______________ History of learning problems? ☐ No ☐ Yes
Current employment: ____

STRENGTHS AND ABILITIES:

What do you think are your strengths and abilities: ______________________________
Describe your family's strengths and abilities: ______________________________

Child or Parent/ Guardian Signature & Date: ______________________________

Clinician Signature & Credentials & Date: ______________________________

Clinician Name (print): ______________________________

Birmingham Maple Clinic

Dr. Chen's Financial Policy

FINANCIAL INFORMATION

1. You are responsible for the timely payment of your account.
2. Your deductible, co-pay, and missed appointment charges are your responsibility to pay, <u>because they are not covered by insurance</u> and are due on the day services are provided or you missed your appointment.
   2A. Your deductible recurs every January. Every insurance policy has different deductible amounts and you are responsible to pay your entire deductible before the insurance pays anything.
3. If your unpaid balance reaches $300.00, your sessions will be suspended until full payment is made.
4. Missed appointment charges must be paid in full before your next appointment.
   4A. The charge for a missed appointment will be discussed with your provider and you will sign a separate document confirming that you are aware of the cost of missed appointments.
5. Payment Agreements may be arranged with Dr. Chen's office to pay off outstanding balances.
   5A. Terms of Payment Agreement include:
      i. The first payment is due at the time of signing the Agreement.
      ii. Payments must be made monthly with a specified due date or a $25 Late Fee will be added to your account.
      iii. If payments are not made monthly, your account will be sent to collections.
6. Failure to pay balance due may result in cessation of services.
7. Dr. Chen accepts cash, check, Visa, American Express, MasterCard and Discover.
8. We encourage you to keep a credit card on file to be charged when there is an outstanding balance. This will prevent lapses in your appointment schedule.
   8A. Credit card information is kept confidential, in compliance with HIPAA regulations, and is only available to particular staff on a 'need to know' basis for purposes of billing.
   8B. It is your responsibility to provide updated credit card information if/when your card expires or you prefer to use a different credit card.
9. For in-person sessions, payment should be made by the parent/guardian who brings a minor to their appointment.
10. Both parents with custody must agree to treatment and payment obligations before beginning therapy.
11. We will not become involved in disputes between individuals regarding payment of the bill.

MISSED APPOINTMENTS

1. Unless cancelled 24 hours in advance, our policy is to charge for missed appointments at the insurance-approved rate and specified in the document you sign with your provider.
2. Keep in mind that insurance companies will not cover this cost and you will be responsible for all Missed Appointment fees.
3. Missed Appointment fees must be paid in full before your next appointment or the next session will be suspended until payment is made.
4. Missing appointments interferes with the outcome of treatment.
5. Please help us serve you better by keeping all scheduled appointments.

REGARDING INSURANCE

1. We will verify and inform you of the financial terms of your insurance coverage before your first visit provided you have shared your insurance information with enough lead time for us to contact your insurance company to verify your benefits.
2. Verification of coverage does not guarantee payment.
3. Insurance is a contract between you and your insurance company, we cannot be a party to this contract.
4. In most cases, we file insurance claims as a courtesy to our clients.
5. Although we supply factual information to your insurance company when necessary, we will not become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance coverage, usual and customary charges, etc.
6. In the event that a third-party payment is denied after services have been provided, you will still be held responsible for the cost of said services.
7. Many insurances do not reimburse for multiple sessions on the same date. If you schedule multiple appointments on the same date, you will be responsible to pay for the session/s that are not covered by your insurance company.
8. This notice will cover Birmingham Maple Clinic and those health care providers who, while not necessarily legally affiliated with us, may provide you with care or treatment at Birmingham Maple Clinic; Dr. Chen, Dr. Klein, and Dr. Weingarden.

NO SURPRISES ACT

1. You are entitled to complete, detailed information about the cost of therapy services at Dr. Chen's office so that nothing in your bill is a surprise to you.
2. If you have insurance for which we are out-of-network, if you have chosen to forgo using your insurance and instead prefer to pay privately for services, and/or if you have requested a service that is not covered by your insurance company, the following information will apply:

   2A. The services you are expecting to receive at Dr. Chen's office includes the following maximum charges. A separate, signed document will specify the charges agreed upon by you and your therapist.

PSYCHIATRIC SERVICES

99205 New Patient Office Visit	$ 400
99204 New Patient Office Visit	$ 325
99215 Established Patients	$ 225
99214 Established Patients	$ 200
99213 Established Patients	$ 175
99212 Established Patients	$ 125

2B. Your provider will discuss the anticipated length of your treatment with you, keeping in mind that as treatment progresses, additional treatment goals and objectives may arise which may extend the length of treatment. Please feel free to discuss your progress and length of stay with your therapist throughout your treatment experience.

THANK YOU FOR TAKING THE TIME TO UNDERSTAND OUR FINANCIAL POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

______________________________ ______________________________

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

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT:

Name: ______________________________ Telephone: ______________

Address: ______________________________

Employer: ______________________________ Telephone: ______________

Employer's Address: ______________________________

Signature of Responsible Party: ______________________________

CLARK CHEN, D.O.
BIRMINGHAM MAPLE CLINIC

INFORMED CONSENT

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

______________________________	______________________________
Patient, Parent or Guardian	Witness
______________________________	______________________________
Date	Date

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 20, 2013

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.

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 health care 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 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.
- Brooke Weingarden, D.O., M.P.H., P.L.L.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 under state law, which we will comply with. 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 and disclose health information about you to arrange for and provide you with treatment, health care or other related services by us or others, and to communicate with other providers such as referring physicians or specialty providers to assist in your treatment. For example, the therapist or psychiatrist treating you may need to communicate with your primary care physician 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 with and your recovery.

- **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 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 the Birmingham Maple Clinic's 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, or evaluate how to improve our facilities and the services we provide.

- **Special Purposes When Permitted or Required by Law.** We may disclose medical information about you for special purposes when permitted or required by law, including the following:

  - To avert a serious threat to health or safety against you, the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat, or to law enforcement authorities in particular circumstances.

  - For public health and administrative oversight activities, such as disease prevention, disease control, abuse or neglect reporting, health and vital statistics, audits, investigations, licensure reviews and reports of births and deaths.

  - For research purposes, limited information may be disclosed as required by law.

  - To workers' compensation or similar programs for the payment of benefits for work-related injuries.

  - To coroners, medical examiners and funeral directors to identify a deceased person, determine cause of death, or to carry out duties.

  - To comply with court orders, judicial proceedings, or other legal processes related to law enforcement, custody of inmates, legal and administrative actions, and criminal activity.

  - For U.S. military and veteran reporting regarding members and veterans of the armed services of the U.S. or foreign military.

  - For national security and intelligence activities such as protective services for the President and other authorized persons.

  - To disaster relief organizations who seek your information during a disaster to coordinate your care or notify family or friends of your location and condition.

- **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.

- **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.

- **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 or relative, personal representative, 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 a hospital.

- **Business Associates**. We sometimes contact with third-party business associates for services. For example, these business associates include billing services, medical transcriptionists, answering services, consultants, and attorneys. We will disclose your medical information to our business associates to the extent necessary for them to perform the requested services. Our business associates are required by law to protect your medical information just as we are required to do so.

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. These may include, but are not limited to, the following: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of health information. If you provide us with 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.

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.

Please note that we may choose not to comply with a restriction request with respect to certain services, unless you choose to pay for the services out-of-pocket, in full, and you request that we not disclose your health information related solely to those services to your insurance provider/health plan.

- **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 reasonable costs of copying, mailing or other expenses 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. In this accounting, we are not required to list certain disclosures, including disclosures made for the purposes of treatment, payment and health care operations; disclosures made pursuant to your authorization or made directly to you; disclosures made incident to a use or disclosure otherwise permitted by law; disclosures made to create a limited data set; and disclosures made for national security or intelligence purposes and disclosures made to correctional institutions or to law enforcement officials.

  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 prior to the date of the request. Your request should indicate in what form you want the list; for example, either 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

In the event that there is a breach of your unsecured health information – meaning an unauthorized disclosure where your health information has not been made unusable, unreadable, or indecipherable – we are required to notify you of such breach.

Upon receiving such notification, or if you believe your privacy rights have otherwise 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.
2075 West Big Beaver Road
Suite 520
Troy, Michigan 48084

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)

CLARK CHEN, D.O.
BIRMINGHAM MAPLE CLINIC

COORDINATION OF CARE CONSENT FORM

I ________________________________, hereby (place X) ____ authorize ____ do not authorize Dr. Chen/ Birmingham Maple Clinic to release and/or obtain confidential information contained in: ______
my _______ my child's patient records to and from the following physician(s):
(If contact not authorized, reason why): ________________________________

Primary Care Physician: ________________________________
Address: ________________________________
Phone: ________________________________ Fax: ________________________________
Purpose of disclosure: ______ Coordination of care ____ other: ________________________________

The use of this consent by Dr. Chen/Birmingham Maple Clinic may be revoked by myself, in writing at any time. This consent is being signed voluntarily and under no circumstances is a precondition of treatment.

I understand that information to be released or requested may include material that is protected by HIPAA and Federal (42 CFR part 2) and/or State law applicable to substance abuse (drug or alcohol), mental health, and/or AIDS/HIV related information and prohibits re-disclosure unless expressively permitted by a written consent of the person to whom it pertains or otherwise permitted by HIPAA or 42 CFR part 2.

Patient Signature: ________________________________ Date: ________________

Parent/Guardian Signature: ________________________________ Date: ________________

Witness Signature: ________________________________ Date: ________________

Information to be completed by provider:

_ Diagnosis: ________________________________
_Medication Information & Dosages: ________________________________
_Assessments/ Testing Information: ________________________________
_ Other: ________________________________

________________________________ ________________________________
Provider Name/ Signature Date

____
Address City State Zip code

________________________________ ________________________________
Phone Number Fax Number

Request to PCP:

____ ***Child/ Adolescent PCP- please send EPSDT screening, physical assessment, & current lab results***
____ other ________________________________