Orlando Matias, D.O., P.C.
2104 Jolly Rd., Ste. 290
Okemos, MI 48864
Phone (517) 220-4507
Fax (517) 575-6869

Name: _____
Legal First Name (preferred name) Middle Last

Date of Birth: _____ Sex (please circle): Male Female Other

Address: _____, MI _____
Street City Zip Code

Home Phone: _____ Cell Phone*: _____ Work Phone: _____
*Please indicate if Home number and Cell number are the same

Which phone number would you like us to use as your preferred number? HOME CELL WORK

Would you like to receive your appointment reminders via text message*? YES NO

Social Security Number: _____ E-Mail Address: _____
By providing your email, we will sign you up to view your patient portal on our website. You can view select medical records, send secured messages to the office, verify your upcoming appointments and more! A username and password will be emailed to you.

Primary Insurance: _____ Secondary Insurance (if applicable): _____

Name of Preferred Pharmacy: _____ Location: _____
Street Name/Nearest Crossroads

If under 18, Parent/Guardian Name: _____ DOB: _____ Relationship: _____

Spouse's Name: _____ DOB: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Address: _____ Relationship: _____

PLEASE CIRCLE ALL THAT APPLY:

Race: Asian Black/African American Hispanic/Latino White Native Hawaiian/Other Pacific Islander
American Indian or Alaska Native Other Race Decline to Report

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Decline to Report

Authorization to Access External Prescription Databases

I hereby authorize the named health care provider Orlando Matias, D.O. to access any and/or all external databases available to healthcare providers in the State of Michigan which reflect the prescription medications filled/ordered/or used by me on a frequency to be determined by the provider. I understand that this information will be used to verify current medications, coordinate care, and to prevent drug interactions. This information will become part of my permanent medical record at Orlando Matias, D.O., P.C.

Assignment of Insurance Benefits/Authorization to Release Information

I hereby authorize direct payment of surgical / medical benefits to Dr. Orlando Matias, D.O. for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Dr. Orlando Matias, D.O. to release any medical / incidental information that may be necessary for either medical care or in processing applications for financial benefit. This information will become part of my permanent medical record at Orlando Matias, D.O., P.C.

PATIENT NAME (please print): _____ DATE: _____

SIGNATURE: _____ PARENT/GUARDIAN (please print): _____

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HIPAA Consent for Verbal Communication

PATIENT NAME: _____

_____ I give permission to physician and/or staff to release my lab, x-ray results, or any information to the people listed below over the phone.

_____ I give permission to physician and/or staff to release my lab, x-ray results, or any information by leaving a message on my answering machine.

_____ I give permission to physician and/or staff to verify, change or cancel appointments by leaving a message on my answering machine.

I understand that this release will stay in effect until written consent is received altering its contents.

Patient Signature: _____ Date: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

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IN REGARDS TO NO SHOW APPOINTMENTS AND FINANCIAL POLICY

The intent of this document is to inform you of Orlando Matias, D.O., P.C.'s Financial Policy. It is our objective that all of our patients receive the best possible care and service. Therefore, your complete understanding of our financial policy as it relates to your financial obligation is essential. Please read this document thoroughly.

***The office now offers telemedicine for certain encounters with Dr. Matias. These encounters are billed like an in-person office visit, where copays, co-insurance and deductibles are applied.

Due to insurance company policy, you are required to be seen by Dr. Matias at least once every three (3) years to remain an active patient of our practice.

** If you are a member of a health plan that Orlando Matias, D.O., P.C. participates with, we will submit your claim to your insurance company**. Your co-payment is expected on the day services are rendered**. Effective January 3, 2017, the billing service fee for any payment not received on the day of service is a **$25.00 additional charge** for each time your copay is not paid. This is an enforceable charge against your account that your insurance carrier does not cover which means those charges will be your responsibility. Patients will be billed in full for any services that their health plan deems as "not a benefit" or a "non-covered service."

** If the provider does not participate with your insurance carrier, payment in full will be your responsibility. Our billing department will send a bill to your insurance company as a courtesy to you.

** There is a charge of **.50 cents per page of medical records request**. Payment for these records will be collected prior to records being released. Copy time is 2-4 weeks depending on staff availability and amount of records requested. If applicable, a complimentary copy of your records will be sent to the physician of your choice.

** A **$35 fee** will be assessed for any check returned for non-sufficient funds.

** Medicare patients are responsible for their deductible, co-insurance and any services Medicare might deem as "Medically Unnecessary." Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form as required by Medicare for some services.

** Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. All patients who do not show up for their scheduled appointments will be charged. This is an enforceable charge against your account that your insurance carrier does not cover which means those charges will be your responsibility.
There are no exceptions according to the insurance carriers. This includes all insurances.
To avoid these charges, you must keep your appointment and be on time or you need to **cancel at least twenty-four business hours prior** to your appointment.

**********NO SHOW/ NON-CANCELLED FEES**:

Regular office visit/Sick Call - $25.00	Pap - $50.00	Physicals - $50.00
Procedures - $50.00	Well child checks - $50.00	

Orlando Matias, D.O., P.C. reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collection fees.

**I have read and understand the financial policy. I hereby agree to pay Orlando Matias, D.O., P.C. for any charges to my account due to a NO SHOW / NON-CANCELLED APPOINTMENT.

Patient/Responsible Party Signature | Relationship to Patient | Date

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Parental Consent for Medical Treatment

Child's information:

Childs Name | Date of Birth

Home Address | City | State | Zip

Parental Contact | Contact number

Caregiver information: (designated adult over the age of 18 authorized to bring minor child to appointments in my absence)

Caregiver's name | Relation to Patient | Phone Number

The above named caregiver shall be authorized to consent to routine and/or emergency treatment for the above named child, which may be required during my absence.

[ ] I give my permission for my child to bring themselves to an appointment(s) in my absence. Established care plans may continue. Any new treatment plan must be approved by me. A summary of care must be given to my child at the visit.

[ ] I give my permission for a caregiver (an adult over the age of 18) listed above to bring minor child to an appointment(s), if I am unable to be present at the time of the appointment.

[ ] This consent will be in effect until ___ day _____ 20___, unless earlier revoked by me.

[ ] This consent for caregiver treatment has no expiration and will be revoked upon written notice only.

This consent serves as permission for treatment by Orlando Matias, D.O., P.C. I acknowledge that parental consent is not required in emergency situations. I agree to pay for all services provided to my child in my absence.

Parent/legal guardian (circle one) | Date

Witness | Date

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Dear Patient,

I am not taking new patients who have recently had an accident, workman's compensation episode or requesting time off work, work restrictions or wanting narcotic pain medication for an existing condition. I will ***not*** give you narcotic prescriptions (examples including but not limited to, Vicodin, Percocet, Oxycontin, etc) for your pain. I will not complete any forms for you concerning medical marijuana, and I will not prescribe any medical marijuana. If that is why you are here, then you will need to find a new doctor, and your brief stay here will not be charged to you or your insurance.

If you are an existing patient in this office; and we suspect a problem with drug use (illicit or prescription) we, as physicians, may request random urine or blood tests.

Patient signature_____ Date:_____

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PAIN CONTRACT
FOR LONG-TERM CONTROLLED SUBSTANCE THERAPY
AND CHRONIC PAIN

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of a relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interaction or poor condition of treatment.)

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:_____ phone:_____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professional who provide your health care for the purpose of maintaining accountability.

5. You may not share, sell or otherwise permit others to have access to these medications.

6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presences of unauthorized substances may prompt referral for assessment for addictive disorder.

8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or have access to them.

9. Original containers of medications should be brought in to each office visit.

10. Since the drugs may be hazardous to lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

12. Early refills will generally not be given.

13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they be filled prior to the appropriate date.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality s waived and these authorities may be given full access to our records of controlled substance administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

17. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.

18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledged that you have received such explanation).

19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Physician signature	Patient signature
Date	Patient Name (Printed)

Orlando Matias, D.O., P.C.
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NOTICE AND ACKNOWLEDGEMENT

Acknowledgment:

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

Patient Signature	Date
Personal Representative Signature and relationship to patient (If patient is a minor)	Date

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Authorization for Disclosure of Medical Record Information

Patient Name: _____ DOB: _____
Address: _____
_____ Phone: _____

I hereby authorize Orlando Matias, D.O., P.C., to

_____ Release information **to:**
Name or title of person or organization:
_____
Address: _____
Phone: _____ Fax: _____

_____ Release information **from:**
Name or title of person or organization:
_____
Address: _____
Phone: _____ Fax: _____

1. Extent or Nature of Information to be Disclosed:
   _____
   (Dates of treatment, diagnoses, progress notes, labs, x-rays, all records, etc.)
2. Purpose or Need for the Disclosure:
   _____
   (Follow up care, lawsuit, etc.)
3. I understand that as set forth in Orlando Matias, D.O., P.C.'s Notice of Privacy Practice, I have the right to revoke this authorization, in writing, any time by sending written notification.

Patient/Parent/Legal Guardian Signature: _____
Relationship: _____ Date: _____
Witness Signature: _____ Date: _____

In addition to the above patient inform, if my records contain diagnoses and or treatment for substance abuse (including alcoholism) and or mental health counseling, and or AIDS, ARC, or HIV testing, I authorize the release of that information under the above conditions. I understand that this specific authorization is needed because the Federal Regulations provide confidentiality of that information.

Patient/Parent/Legal Guardian Signature: _____
Relationship: _____ Date: _____
Witness Signature: _____ Date: _____
Reason Patient Cannot Sign: _____Minor _____Deceased _____Other: _____

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Patient Center Medical Home (PCMH): is a trusting partnership between a physician and an informed patient. It includes an agreement between the doctor and the patient to work together to provide the overall goal of wellness.

We will:
- Ask what your goal is, or what you want to do to improve your health
- Ask you to help us plan your care, and to let us know if you think you can follow the plan
- Be a resource if medical knowledge to provide you with information about your condition in understandable terms
- Provide you with compassionate care to treat your medical conditions and specific diagnosis
- Ask you to have blood tests done before your visit so that the doctor has your results at your visit
- Explore methods to care for you better, including ways to help you care for yourself

We trust you, our patient, to:
- Tell us what you know about your health and illnesses
- Tell us about your needs and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon - or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- Let us know when you see other doctors and what medications they put you on or change
- Ask other doctors to send us a report about your care when you see them
- Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Respect us as individuals and partners in your care
- Keep your appointments as scheduled, or call and let us know when you cannot
- Pay your share of the visit fee when you are seen in the office
- Give us feedback so we can improve our services (we may survey you in the future to understand this better)
- **Test results:** Our office will notify you regarding abnormal tests within 2 business days of receiving them by phone or letter. In the event they are abnormal we may ask to schedule an appointment to discuss them with your physician
- If you have not heard from this office in one week and would like to know your results, please call us.

We will continue to:
- Provide you with a care team who will know you and your family and provide care management services
- Respect you as an individual
- Respect your privacy: your medical information will not be shared with anyone unless you give us permission or it is required by law
- Give the care you need when you need it
- Give care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Offer you access to a physician 24 hours a day and 7 days a week
- Take care of short illness, long term disease and give advice to help you stay healthy
- Explain your health and illnesses in a way you can understand
- Evaluate and incorporate healthcare technology in the practice of medicine
- Provide you with community resource information

SERVICES AVAILABLE

- Family medicine
- Pediatrics
- Pap smears
- Wart removals
- Mole removals
- Toe nail removal
- Sutures and Suture removal
- Diabetic patients
- Lab services on site

HOURS OF OPERATION:
8:00 - 5:00 PM MON - THURS
8:00 - 12:00 PM FRIDAY
Most insurances accepted

AFTER HOURS: 517-226-5772
Is the physician's pager number.

AFTER HOUR CLINICS:

Sparrow Urgent Care
517-333-6562
Hours: 8a - 8p, East Lansing

Orlando Matias, D.O., P.C.
2104 Jolly Rd., Ste. 290
Okemos, MI 48864

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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Uses and Disclosures of Protected Health Information

The practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Disclosures of your protected health information for the purposes described in this Notice may be in writing, orally, or by facsimile.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care.

Payment

Your protected health information will be used, as needed, to obtain payment for services that we provide. This may include certain communications to your health insurer to get approval for the treatment recommended. If a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the hospitalization, or whether a particular service is covered under your health plan. We may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the service.

Operations

We may use or disclose your protected health information for:

- Employee review activities, business, or administrative activities
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision
- Accreditation, certification, licensing, or credentialing activities, legal services and maintaining compliance programs

Other Uses and Disclosures

We may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment, via phone messages, voicemail messages or postcards
- To remind you of health-related benefits or services that may be of interest to you, sign in sheets, computerized appointments or encounter forms

Uses and Disclosures beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

Legal Requirements

We will disclose your health information when we are required to do so by any Federal, State or local law.

Public Health Risks

We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law
- To report vital events such as birth or death as permitted or required by law
- To conduct public health surveillance, investigations and interventions as permitted or required by law
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA nd to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required

To Report Abuse, Neglect or Domestic Violence

We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence, when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will

not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

We may disclose your protected health information in the course for any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

Law Enforcement

We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Court order, court-ordered warrant, subpoena, or summons
- For identifying or locating a suspect, fugitive, material witness or missing person. If you are the victim of a crime
- If the practice has a suspicion that your death was the result of criminal conduct, or in an emergency to report a crime

Coroners, Funeral Directors, and for Organ Donation

We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research Purposes

We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board.

Serious Threat to Health or Safety

We may use or disclose your protected health information if we believe, in good faith, it is necessary to prevent or lessen a serious and imminent threat to your health and safety of the public.

Specified Government Functions

In certain circumstances, the Federal regulations authorize the practice to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

Worker's Compensation

The practice may release your health information to comply with worker's compensation laws or similar programs.

Family and Friends

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. You may object to these disclosures, however in our professional judgement, we feel it is in your best interest for your care, we may disclose your protected health information.
Other than stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Inspect and Copy Information
You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain it. This contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under **Federal** law, however, you may not inspect or copy the following records: psychotherapy notes, or information for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgement, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect a copy, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, there will be a fee for copying, mailing or other costs incurred by the practice.

Request a restriction on uses and disclosures
You have the right to request restrictions be placed on your protected health information as to what can be used and disclosed and restrictions as to who we may or may not disclose to. We are not required to agree to these disclosures, but if we do we will abide by our agreement, except in an emergency situation. Under certain situations, we may terminate our agreement to a restriction.

Alternative Communication
You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may ask you for information as to how payment will be handled of an alternative address or other method of contact. Requests must be made in writing to our Privacy Officer.

Amend your protected health information
You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing to our Privacy Officer. You must also provide a reason to support the requested amendments.

Receive an accounting

You have the right to request an accounting of certain disclosures of your protected health information made by the practice. This applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer, and should specify the time period for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable fee.

Our Duties

The practice is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by the terms of this Notice which may be amended from time to time. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all protected health information that we maintain. If the practice changes its Notice, we will provide a copy of the Revised Notice via regular mail or through in-person contact.

Complaints

You have the right to express complaints to the practice and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the practice by contacting the practice's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The practice's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Officer.

Privacy Officer: Georgeanne Matias

Telephone: 517-220-4507
Fax: 517-575-6869

Address: 2104 Jolly Road, Suite 290
Okemos, MI 48864

This Notice is effective January 3, 2017.