`	**Michael Geis, *D.O.*** 1435 Bedford Street Suite 1R Stamford CT, 06905	Ht: ____'_____" Wt: _____ lbs	Do Not Write In This Box

Today's Date:_____-_____-_____

Please print the following information:

Name: _____Date of Birth: _____-_____-_____

Address: _____

_____ E-mail: _____

Phone: Home_____Work_____Cell_____

Please check if you do NOT want us to leave messages at: Home [ ]Work [ ]Cell [ ]

Occupation:_____

Employer:_____

1. Insurance Company: _____ Policy Number:_____
Name on Policy: _____Group Number: _____
Policy Holder Date of Birth: _____-_____-_____
2. Insurance Company: _____ Policy Number:_____
Name on Policy: _____Group Number: _____
Policy Holder Date of Birth: _____-_____-_____

Significant Other/Spouse:_____

Closest Relative/Person to notify in case of emergency:_____
Relationship: _____ Phone: _____

Referred by:_____
Allergies: _____

Physicians from whom you are currently receiving medical care:

Physician	Condition you are being treated for	Medications

Surgeon	Date	Surgical procedure and reason performed

Are you currently on Disability? _____Worker's Comp?_____

Is the condition that you are seeking help for the result of a motor vehicle accident? _____

PLEASE ALSO READ AND SIGN THE NEXT 4 PAGES. THANK YOU.

Michael Geis, D.O.

1435 Bedford Street Suite 1R
Stamford CT, 06905

Private Contract

This agreement is between Michael Geis, D.O. whose place of business is 1435 Bedford Street Suite 1R Stamford CT, 06905 and
Patient: _____
Who resides at: _____
_____

Patient or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Patient or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Patient or his/her legal representative understands that insurance limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Patient or his/her legal representative acknowledges that the patient is not currently in an emergency or urgent health care situation.

_____ Patient or his/her legal representative acknowledges that a copy of this contract has been made available to him/her.

Executed on:

_____
Date

By:

_____
Patient or his/her legal representative

And:

_____
Michael Geis, D.O.

Michael Geis, D.O.
1435 Bedford Street Suite 1R
Stamford CT, 06905
Today's Date: _____-_____-_____

Name: _____Date of Birth: _____-_____-_____
Please print

1. Permission to Share Information with Health providers:

If you want the doctor to share your medical information with other health providers so that we may function as a team please give permission:

Signature: _____ Date: _____

[ ] Please contact me before sharing any information with my other health providers.

2. Permission to release information to Insurance Carriers:

We must have your authorization in order to respond to any correspondence from your insurance carrier. At times we receive Explanation of Benefits forms from insurance carriers. They may have used incorrect codes or they may classify codes incorrectly. We have form letters to send to correct these errors in order for you to receive appropriate reimbursement. Please sign below so that we may help you obtain reimbursement.

I give permission to this office to release medical information to my health insurance company.

Signature: _____ Date: _____

[ ] Please contact me when you receive **any** requests for information from my insurance carrier.
[ ] Please contact only when there are requests for copies of your office notes.

3. Patient Privacy Policy:

I have read and understand Dr. Geis' attached Patient Privacy Policy. In respect to patients' privacy and security and the requirements of the Health Information Privacy Act (HIPA), I agree to maintain the Patient's Privacy Policy of this office.

Signature: _____ Date: _____

Michael Geis, D.O.
1435 Bedford Street Suite 1R
Stamford CT, 06905

Welcome:

To help you get acquainted with the office, we have prepared a few words about our policies and fees. Please read this so that you understand the guidelines and sign below.

Office hours:

Office hours are on Monday-Friday. We make every effort to examine newborn infants as soon after birth as possible.

Your Appointment:

Your appointment is time set aside for you to see the Doctor. We have a twenty-four (24) hour cancellation policy: if you cancel an appointment less than 24 hours prior to its scheduled time **you will be billed one-half the visit fee.** A message may be left on our answering machine at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and make every effort to be punctual for your appointment.

Fragrances:

Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays, we would appreciate it if you refrain from wearing these to the office.

Fees & Payment:

Regardless of insurance we require payment for services at the time they are provided. We supply a standard itemized receipt that you may submit to your insurance company in case you qualify for reimbursement. We regret that we are unable to accept assignment from your insurance carrier.

If your check is returned from the bank we will add a $30.00 "returned check" fee to your account.

Children:

Children must be supervised and remain in the waiting area only. Please do not allow children to roam about other rooms or open closed doors. Beware of scalding HOT water in bathroom sink.

Thank you for taking your time to read this policy sheet. If you have any questions please ask them now.

We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above office policy and consent to treatment by Dr. Geis.

_____ _____

signature date

_____

print name

Michael Geis, D.O.
1435 Bedford Street Suite 1R
Stamford CT, 06905

Patient Privacy Policy

In order to protect sensitive personal and medical information we have instituted a number of measures aimed at maintaining your privacy. The National Institutes of Health have developed the Health Insurance Portability and Accountability Act (HIPAA) that requires every medical provider to make a privacy policy available to patients. This effort is to maintain privacy of patient information in an era of technology and data-laden medical systems. The end result will be a more streamlined system of medical information with a higher degree of information security in the process. The following is the policy regarding patient privacy and confidentiality of information collected and stored in this office:

1. Payments and Scheduling will be done by the office manager (or the doctors). **Patients must remain in the waiting area and NOT at the office manager's desk** so that the schedule book and computer screen are NOT visible to them.

2. An information sheet with demographic data, insurance information, consents for treatment, and medical disclosure will be completed by every patient as part of her/his record. A copy of this sheet and the insurance card(s) will be released to our office manager for billing records and to help process medical claims. This form will include the patient's preferences for where messages may be left, (home, work or cell phone).

3. All superbills for office visits will be shared with the office manager in order to process insurance claims and record business transactions for tax purposes.

4. Any paper trash with patient information will be shredded prior to discarding it.

5. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting which is not to be discussed or revealed to any person(s)/business(es) outside of the office setting without prior written consent by the patient/legal guardian.

6. Medical release forms are required to be signed by the individual or parent/guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. A copying charge may apply for extensive record copying.

7. Only first names will be used when addressing patients in the office. All medical related conversations will occur in private.

8. All papers related to patient care will be stored in cabinets when not in use where only authorized medical staff has access to them.

Any breech of confidentiality must be submitted in writing to Dr. Geis for proper action to be taken to amend the situation and/or policy.

_____ _____
signature date

_____
print name