NEW PATIENT FORMS PACKET
FOR THE PRACTICE OF MICHAEL D. RANDELL, MD

ALL FORMS AND ALL PAGES (not just the signed pages) MUST BE PRINTED SINGLE-SIDED AND RETURNED TO THE OFFICE.

:

Welcome to our practice! We are extremely honored that you have chosen us for your gynecological care.

Included in this packet are the following important forms:

1) Registration
2) Request & Authorization To Release Healthcare Information
3) 2020 Patient Letter
4) Patient Personal History
5) Hereditary Cancer Questionnaire
6) HIV Antibody Testing
7) HIPAA Notice of Privacy Practice
8) Authorization to Disclose Information
9) Request for Restriction on Use of Information (optional)
10) Assignment of Benefits
11) Billing Statement Information

Please print and complete these forms prior to your visit. **Do not print on the back of any pages.** Once you have completed these forms, you may fax them to our office at (404) 250-4423 or you can scan and e-mail them to our office at office@obgynatlanta.com. Please be aware that e-mail and fax transmissions can be misdirected, so please make sure that you are sending your forms to the correct fax number or email address.

In order to protect your privacy, please do not communicate any highly sensitive health information via fax or email. Instead, please write this information on a separate sheet of paper and provide the information to Dr. Randell during your consultation.

Please bring these completed forms as well as any relevant medical records (such as prior operative reports, pathology reports, ultrasound reports, and MRI CDs) to your appointment.

For your convenience, our website (www.obgynatlanta.com) contains detailed driving directions to our office. This information is contained under the “Location” tab at the top of our website. Our website also contains information about insurance and other financial responsibilities.

Thank you for completing these forms in advance of your visit. We look forward to meeting you and providing you with excellent care.

Registration Form

Michael D. Randell, M.D., F.A.C.O.G.

DATE _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle Name Maiden Name

Address _____ Home Phone _____
Street City & State Zip Code

Fax _____ Mobile Phone _____ Email _____

Birthdate _____ Age _____ Marital Status S M W D SS# _____

Employed By _____ Occupation _____ Work Phone _____

Address _____
Street City & State Zip Code

Spouse's Name _____ Spouse's SS# _____

Spouse's Employer _____ Spouse's Work Phone _____

In Case of Emergency Contact _____ Phone Number _____

Referred By _____

Name & Phone Number of Nearest Relative Not Living With You _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL

Guarantor Name _____

Address _____
Street City & State Zip Code

Home Phone No. _____ Work Phone No. _____

Employed By _____ How Long? _____ Occupation _____

SS # _____ Relationship to Patient _____

INSURANCE INFORMATION

Do you have insurance to cover the fees for services rendered? ❑ Yes ❑ No

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Insured		Name of Insured	
Primary Insurance		Secondary Insurance	
Primary Insurance Address		Secondary Insurance Address	
Identification #		Identification #	
Group #	Effective Date	Group #	Effective Date
Insured's Date of Birth		Insured's Date of Birth	

AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment (if applicable) of my Medicare benefits either to myself or to the party who accepts assignment.

_____
Signed Date

I authorize payment of medical benefits to Michael D. Randell, M.D., P.C. for services performed. I understand that I am responsible for payment regardless of insurance coverage

_____
Signed Date

registration

Michael D. Randell, MD, FACOG

Fellow, American College of Obstetricians and Gynecologists
Diplomate, American Board of Obstetrics & Gynecology

Specializing in minimally invasive gynecologic surgery and robotics

5667 Peachtree Dunwoody Road, Suite 280 Atlanta, Georgia 30342
Phone: 404.250.4443 | Fax: 404.250.4423 | E-mail: office@obgynatlanta.com | Website: www.obgynatlanta.com

REQUEST & AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(ALL INFORMATION MUST BE COMPLETED)

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize the practice identified to the right to release healthcare information of the patient named above to:

MICHAEL D. RANDELL, MD, FACOG
5667 Peachtree Dunwoody Road, Suite 280
Atlanta, Georgia 30342
Fax: 404.250.4423 Email: office@obgynatlanta.com

Practice
Name:_____
Address:_____
City, State, Zip:_____

Phone_____ Fax_____

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

[List here]

○ All healthcare information ○ Other

[Additional information]

Definition: Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to Dr. Randell.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to Dr. Randell.

Patient Signature: _____ Date Signed:_____

THIS AUTHORIZATION HAS NO EXPIRATION UNLESS WITHDRAWN IN WRITING.

GYNECOLOGY ◆ INFERTILITY
ENDOSCOPIC & ROBOTIC SURGERY

MICHAEL D. RANDELL, M.D., F.A.C.O.G.
Diplomate, American Board of Obstetrics and Gynecology

IMPORTANT INFORMATION ABOUT OUR PRACTICE

2020 Patient Letter and Agreement

Dear Patient:

Thank you for selecting our medical practice for your gynecological care. We look forward to providing you with world-class comprehensive women's healthcare. Please review this Agreement carefully. It explains, in general, our policies and procedures regarding how our practice works, and our fee arrangements and billing methods. If you have any questions regarding these terms, please do not hesitate to contact us. Please sign this letter after you have read it.

1. **How We Work**. Dr. Randell is in private, solo practice. In most circumstances, appointments can be made twenty-four hours in advance. Dr. Randell usually sees patients three days a week and operates two days a week. In addition to taking care of patients, Dr. Randell has teaching and administrative responsibilities that may require him to be out of the office on days that he is scheduled to see patients or operate. If this happens, our office will contact you to reschedule your appointment or surgery to a mutually convenient time. Dr. Randell will personally perform all surgeries and other services that are scheduled with him.

We believe that the delivery of first-rate healthcare requires that the patient be informed of the results of various tests. If you have not heard from our office within four weeks of your visit regarding test results, please do not hesitate to contact us via the "help button" on our website (www.obgynatlanta.com).

2. **Fees.** We generally bill patients for all services performed in the office and in the hospital. If you have insurance, please present your valid insurance card at each visit. As a courtesy, we will bill your insurance company for all covered services within 90 days of service. However, you will be responsible for paying all co-pay, deductible, and co-insurance amounts at the time services are rendered. In addition, you will be responsible for paying the costs associated with all non-covered services including, without limitation, providing third parties with medical records and information regarding your care as is requested. Special robotic and advanced laparoscopic surgery, fertility care, and other procedures as determined by the Practice, may incur additional charges that are not covered or not billed to your insurance company. If we are not contracted with your insurance company, you will be offered a discounted rate.

Prior to having surgery we will check your insurance benefits and determine an estimate of the amount likely to be your responsibility. Such estimates are not maximum amounts, however, and the actual amount often differs from the estimated amounts. You will be responsible for paying the estimated amount (and any deductible and co-insurance amount) and non-covered charges in full at your preoperative appointment (usually the week of or one week before your surgery). We accept payment by certified bank check or cash. We do not accept credit cards for surgery related fees.

When Dr, Randell treats you via the telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis and treatment (i.e., calling in a new prescription or refill into a pharmacy) the office may charge up to a $50.00 professional fee (not covered by insurance) to your credit/debit card on file. There is never a charge for addressing postoperative problems and urgent medical issues. *Please call 911 or go to the closest emergency room for all life-threatening conditions.*

We also charge for copying medical records and completing forms for your work or school. Fees are set in accordance with Georgia Law and must be paid prior to record delivery or form completion. Requests for copies of medical records must be in writing and contain your full name, telephone number, mailing address, email address, date of birth, last 4 numbers of your Social Security number and your signature.

There is a $175.00 non-refundable Administrative Service Fee charged only for all gynecological patients having surgery. This fee will cover all administrative services including, without limitation, surgical scheduling, coordinating hospital services, completing FMLA forms, completing return to work forms, writing of letters, and all other administrative matters not covered by insurance. This fee must be paid before we complete any forms or letters.

3. **Billing Statements**. We generally, but not always, bill patients on a monthly basis. Your bill will include a description of services performed and any payment made by your insurance company on your behalf. You may also receive separate billing statements from the laboratory, hospital, and/or surgical assistants. Some bills may arrive years after the services were provided depending on myriad factors such as insurance recoupments, incorrect processing, etc. Credits on your account will be applied to outstanding or future balances and will not be refunded, except under special circumstances. The insurance explanation of benefits governs what you are responsible for paying.

Your balance for our practice is due and payable in full immediately upon receipt of your statement sent to your email address that you provide to the Practice. It is our policy with new patients or with existing patients concerning certain matters, to request to have your credit/debit card information on file. You agree to allow us to charge your credit/debit card any outstanding account balance of the invoice at anytime as determined by the Practice, or if your invoice is returned to us as undelivered. Additional processing fees will apply. Further, you agree to pay us for any expenses (including legal fees and courts costs) we incur in connection with the collection of your past due account. You agree to not dispute with your credit card company any charges billed to your credit/debit card for charges as described in paragraphs 2, 3, and 4. Finally, you agree to settle all disputes under this Agreement in Fulton County Georgia Magistrate or State Court and you agree to waive your right to any other venue.

If you should ever have a question about a billing statement or our billing procedure, you should contact us immediately in writing, not by phone, using the "help button" on our website (www.obgynatlanta.com); otherwise, the billing statement is acceptable to you as presented. For your convenience, you can use your credit/debit card to pay your bill over the telephone or online. There will be a $10.00 convenience fee charged to your credit card that is not refundable.

If you have insurance, you should speak with your insurance company about any billing questions. Our billing is based on the explanation of benefits (EOBs) that we receive from your insurance company. Occasionally, your insurance company may send payments directly to you for services we have provided. You agree NOT to keep any such payment(s) and will forward ALL such payment(s) to us immediately. If you convert any insurance payment(s) intended for the Practice for your own use, you understand that the Practice has the right to take action against you and you agree to compensate the Practice for all expenses incurred in connection with the collection of this payment from you.

4. **Cancellations**. Please notify us by email at least 24 hours in advance if you need to cancel or change your appointment (14 days in advance for surgery). There will be a $50.00 fee ($300.00 fee for surgery) automatically billed to your credit/debit card in the event that you do not show up for a scheduled appointment or you cancel or change your appointment less than 24 hours (14 days for surgery) in advance. Fees also apply to same-day cancellations. (Same-day cancellations include showing up for an appointment and refusing to pay.) The cancellation fee is never waived, is non-refundable and you agree to not request a refund from us and to not dispute the charge with your credit/debit card company. If your credit/debit card is rejected, you agree to pay us an additional amount of $150.00. Surgeries scheduled less than 14 days in advance that are cancelled anytime afterwards will incur the $250.00 cancelation fee.

5. **Our Commitment**. Dr. Randell regards his relationship with his patients as an inviolable trust based on respect, compassion, and concern for good health. We are proud of our high standard of work, and we care how our patients feel about the services we provide. Patient satisfaction and confidence that our practice provides the highest level of care is at the core of our service commitment. If at any time you, as a patient of our practice, do not feel we are living up to this commitment, please notify us promptly.

I have read and reviewed each of the terms of this legally binding Agreement. All of my questions have been answered. I agree to each of the terms. I fully understand what I am signing.

_____ _____

Patient Signature **Date**

_____ _____@_____._____

Patient Name (Printed) **Email Address**

Patient's Personal History

Michael D. Randell, M.D., F.A.C.O.G.

Date: _____

Please complete these forms. If you do not understand any of the questions, please ask the doctor.

This is a confidential record. Information contained here will not be released except when you have authorized us to do so.

Name _____
Last Name First Name Middle Name

Race _____ Religion _____

Family History

	If Living			If Deceased	
	Sex	**Age**	**Present Health**	**Age at Death**	**Cause**
Father					
Mother					
Brothers/Sisters					
Husband					
Sons/Daughters					

Do you or any member of your family have or ever had? (Please circle & give relationship)

Asthma _____
Diabetes _____
Hepatitis _____
Bleeding Tendency _____
Cystic Fibrosis _____
Mental Retardation _____
Downs Syndrome _____
Hydrocephalus/Spina Bifida _____
Tay Sachs _____
Colitis/Ulcers _____

Epilepsy _____
Heart Disease _____
High Cholesterol Level _____
Heart Defects _____
High Blood Pressure _____
Stroke _____
Herpes _____
Goiter/Thyroid Problem _____
Congenital Defects _____
Sexually Transmitted Disease _____

CANCERS (family or self):

Breast _____
Cervix _____
Uterus _____

Ovaries _____
Colon _____
Other _____

Name: _____

Personal Medical History

MEDICATIONS:
Are you presently taking any of the following medications? (Please circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis (Heart pills)	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water Pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or “poor blood” medications	Yes	No	Barbituates
Yes	No	Laxatives	Yes	No	Birth control pills, brand name:_____
Yes	No	Sleeping Pills	Yes	No	Phenobarbital
Yes	No	Thyroid Pills	Yes	No	Other drugs not listed - If so, please list.

_____

_____

OPERATIONS:
List the operations (major or minor) you have had as well as the hospital location and date:

_____

_____

_____

ILLNESSES OR DISEASES:
List the names of any diseases or illnesses you have now or had in the past:

_____

_____

_____

ALLERGIES:
List the names of any drugs to which you are allergic and state the reaction you have had:

_____

_____

_____

INJURIES OR ACCIDENTS :
List any serious injuries or accidents you have had and the date:

_____

_____

_____

Name: _____

Personal Medical History
Continued

MENSTRUAL HISTORY:

Age of onset of menses_____ Duration of menses_____ Interval between menses_____

First day of last menstrual period_____

Please circle

Yes No Have you ever missed a period except when pregnant?

Yes No Has your period ever lasted more than eight days or less than two days?

Yes No Did you ever pass large clots during your period?

CONTRACEPTIVE HISTORY:

Please circle

Yes No Have you ever taken birth control pills?

Yes No Are you presently taking birth control pills? Which one?_____

If no, what form of contraception do you use?_____

OTHER:

Please circle

Yes No Do you have urinary problems? Please explain:

_____

_____

Yes No Do you have varicose veins?

Yes No Do you have phlebitis or inflamed leg veins?

PERSONAL HABITS & PRACTICES:

Please circle

Yes No Do you regularly smoke? Cigarettes_____ Packs/day_____ For how many years?_____

Yes No Do you usually drink over 4 cups of coffe per day?

Yes No Do you regularly drink alcohol? 1 oz. per day ❑ 2 oz. per day ❑ 4 oz. per day ❑ over 5 oz. ❑

Yes No Beer: 1 bottle per day ❑ 2 bottles per day ❑ over 4 bottles per day ❑

Yes No Do you regularly have a Pap smear?

Date and result of last Pap smear_____

❑ Normal ❑ Abnormal

Yes No Do you regularly perform monthly self breast examinations?

Yes No Have you ever had a mammogram?

If yes, date and result of last mammogram_____

Yes No Have you ever had your cholesterol checked?

If yes, date and result_____

Name: _____

Personal Medical History
Continued

OBSTETRICAL HISTORY (including miscarriages and elective abortions):

Date (Month/Year)	Full Term, Premature, Or Abortion	Vaginal or C-Section Delivery	Hours In Labor	Sex & Birth Weight	Complication Mother or Baby

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth _____ Date: _____

Instructions: Please circle **Y** to those that apply to **YOU and YOUR FAMILY** (Both mother's and Father's Side). Behind each statement, please list the relationship **TO YOU** of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) **and their age at diagnosis**. If you circle **Y** to any statements below, you **MAY** be appropriate for genetic testing. Your healthcare provider will have additional information for you.

		Relationship	Age at Diagnosis
Y N	Breast Cancer before age 50	_____	_____
Y N	Ovarian Cancer	_____	_____
Y N	Breast Cancer in both breasts or multiple breast cancers	_____	_____
Y N	Both breast and Ovarian Cancer (in an individual or a family)	_____	_____
Y N	Male Breast Cancer	_____	_____
Y N	2 or more Breast or Ovarian Cancers (in an individual or a family)	_____	_____
Y N	Ashkenazi Jewish ancestry and personal Family history of breast or ovarian Cancer	_____	_____

COLON AND UTERINE CANCER

Y N	Uterine Cancer before age 50	_____	_____
Y N	Colorectal Cancer before age 50	_____	_____
Y N	Both Uterine and Colorectal Cancer (in an individual or a family)	_____	_____
Y N	2 or more Uterine or Colorectal Cancers (in an individual or a family)	_____	_____
Y N	Uterine and/or Colorectal Cancer AND Ovarian Stomach, kidney/urinary tract, brain OR small Bowel cancer (in an individual or family)	_____	_____
Y N	10 or more Colon Polyps found in a lifetime.	_____	_____

Candidate for further risk assessment and/or genetic testing
Information given to patient to review
Follow-up Appointment Date:_____

Patient offered genetic testing
Accepted **Rejected**

_____ _____ _____
Patient Signature Date Physician's Signature

HIV Antibody Testing

Acknowledgement of Counseling & Consent for Voluntary AIDS Testing

Michael D. Randell, M.D., F.A.C.O.G.

Patient Name: _____ Date: _____

The American Medical Association recommends that I offer patients rountine voluntary testing for antibody to the AIDS virus. Women at higher risk for carrying the AIDS virus are:

a. Those women with a history of intravenious drug use.
b. Those women who have sexual contact with homosexual or bisexual males.
c. Those women who have had blood transfusions prior to March 1985.
d. Those women not having a monogamous sexual relationship.
e. Those women who have had sex with a partner who is at risk.
f. Those women who immigrate from a country with a high rate of AIDS.
g. Those women who have had artificial insemination.
h. Those women who have been raped.

The HIV antibody test is not always accurate. The test may result in a false negative by failing to detect antibodies to the virus which are in the blood. This test may also result in a false positive by indicating that there are antibodies which are not really in the blood.

For my pregnant patients, I want you to know that the AIDS virus is freely transmitted to the fetus. Newborns infected with the AIDS virus usually do not survive.

I will keep your test results as part of your complete medical record, and will not release that information without your consent, unless required or authorized by law.

My signature below acknowledges that:

a. I have read or someone has read to me this form, and I understand this consent form.
b. All questions regarding the HIV antibody test have been answered.
c. I understand that further information and counseling is available from the Georgia Department of Human Resources.
d. I give permission to collect one or more blood specimens from me (as in other blood tests) to detect whether I have antibodies in my blood to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).
e. I consent to the release and use of my test results as set forth above.
f. If I am consenting on behalf of another, I confirm that I am the patient's parent, legal guardian, or next of kin, and that the patient is unable to sign because:_____
_____

_____ I request to have the AIDS test done at this time. _____ I **do not** request to have the AIDS test done at this time.

_____ _____ _____

Signature Relationship to patient Date

Michael D. Randell, M.D., P.C.
HIPAA Notice of Privacy Practices
Effective Date: April 14, 2003

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.

If you have any questions about this notice, please contact Dr. Randell.

OUR OBLIGATIONS:

We are required by law to:
- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to Dr. Randell.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose

such information to an entity assisting in a disaster relief effort.

Research and Education. Under certain circumstances, we may use and disclose Health Information for research or education. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Marketing. With your consent, we may use and disclose Health Information for marketing purposes. For example, you may be asked to participate in a health story on television or in printed media. Before we use or disclose Health Information for marketing purposes, we will obtain your approval.

Business Associates. There are some services provided in the office through agreements with business associates. One example is billing, nursing, and general office services. We may disclose your healthcare information to our business associates so that they can perform the job we have asked them to do. We require the business associate to safeguard your information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient 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.

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

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. Randell. An administrative fee and a per page copy fee will be charged to you according to Georgia Law and you will be required to pay this fee prior to the release of your records.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Dr. Randell stating a reason that supports your request.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Randell. We will charge you for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Randell. ***We are not required by Federal regulation to agree to your request.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to Dr. Randell. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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. You may obtain a copy of this notice at our web site, www.obgynatlanta.com. To obtain a paper copy of this notice, please contact the front office receptionist.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Randell. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE:

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices from the office of Michael D. Randell, M.D., P.C.

Print Full Name

Signature

Date

Witness

Authorization to Disclose Health Information to Family Members and Friends

I hereby authorize Michael D. Randell MD, PC ("The Practice") to release my protected health information ("PHI") as described below:

		Type of Information Allowed to Disclose [Check one or both]		Method of Disclosure [Check one or both]	
Name	Relationship	Medical	Billing	By Phone	In Person

[Check One] I DO ____ DO NOT_____ give permission to The Practice to leave information on my answering machine (or voice mail) and/or with my family members (named above) in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments [time, date, location] to be left on an answering machine (or voice mail) or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of The Practice. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, The Practice will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

Name of Patient Date

_____

Signature of Patient

Patient Request for Restriction on Use or Disclosure of Protected Health Information

The privacy of your Protected Health Information is protected by HIPAA. However, the Practice is permitted by HIPAA to use and disclose your protected health information, with certain limits and protections, for treatment, payment and health care operations activities. Pursuant to HIPAA, you have the right to request restrictions on the Practice's use and disclosure of your protected health information for treatment, payment or health care operations activities. The Practice is not required to agree to your request for restrictions, but if the Practice does agree to your request, it is bound by that agreement and cannot use or disclose your protected health information in a manner inconsistent with an agreed-upon restriction.

Today's Date:_____ Patient's Birth Date: _____

Patient's Name: _____

I request that the Practice restrict the use and disclosure of my protected health information ("PHI") for purposes of treatment, payment or healthcare operations as follows:

---

1. I understand that the Practice is not required by HIPAA to agree to this restriction, unless the restriction concerns a disclosure to a health plan for purposes of carrying out payment or health care operations and such disclosure is not otherwise required by law and the restriction concerns PHI which pertains solely to a health care item or service for which the Practice has been paid out of pocket by me in full.

2. If the Practice agrees to this restriction, I understand the restriction may be terminated at any time. A termination of this restriction is effective for PHI that the Practice creates or receives after the date it informs me of such termination. Restrictions concerning a disclosure to a health plan for purposes of carrying out payment or health care operations where such disclosure is not otherwise required by law and concerns PHI which pertains solely to a health care item or service for which the Practice has been paid out of pocket by me in full will not be terminated unless I request such termination in writing.

3. Even if the request is granted, I understand that restricted PHI may be used or disclosed to provide emergency treatment for me or as otherwise required by law. However, the emergency treatment provider will be asked not to redisclose any restricted PHI.

4. I understand that in accordance with other applicable law, the types of uses and disclosures I have written above may or may not be otherwise permitted.

5. I also understand that my right to request restrictions under this HIPAA provision only extends to use or disclosure for treatment, payment or health care operations. My right to authorize the use and disclosure of protected health information for other purposes (or to withhold consent) is addressed in separate policies and the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Personal Representative (if applicable) Date

For Organization Use Only:

Action taken (CHECK ONE): ( ) Granted ( ) Denied (if denied, state reason)

_____ _____

Signature of Staff Person Date

Lifetime Authorization, Assignment Of Benefits, Release of Information, ERISA Representative Form

Financial Responsibility

I have requested professional services from Michael D. Randell, MD, PC d/b/a OBGYN Atlanta ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated with the Provider.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including, without limitation, co-payments, co-insurance, deductibles, administrative service fees, and other non-covered fees.

Assignment of Medicare and/or Medicaid Benefits

I hereby certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or Georgia Medical Care Foundation or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the Provider.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient or authorized representative name Date

_____

Patient or authorized representative signature

IMPORTANT INFORMATION ABOUT YOUR BILLING STATEMENTS
From Michael D. Randell, MD d/b/a OBGYN Atlanta

We generally, but not always, bill patients on a monthly basis. Your bill will be sent via email and will include a description of services performed and any payment(s) made by your insurance company on your behalf. Some bills may arrive years after the services were provided depending on myriad factors such as insurance recoupments, incorrect processing, etc. Credits on your account will be applied to outstanding or future balances.

Your balance for our practice is due and payable in full immediately upon receipt of your statement. It is our policy with new patients or with existing patients concerning certain matters, to request to have your credit card information on file. You agree to allow us to charge your credit card any outstanding account balance of the statement at anytime as determined by the practice. Additional processing fees will apply. Further, you agree to pay us for any expenses (including legal fees) we incur in connection with the collection of your past due account. Finally, you agree to not dispute with your credit card company any charges billed to your credit card for valid charges.

If you should ever have a question about a billing statement or our billing procedure, you should contact us immediately in writing; otherwise, the billing statement is acceptable as presented. For your convenience, you can use your credit card to pay your bill over the telephone or online (payment.obgynatlanta.com). There will be a $10.00 convenience fee charged to your credit card. Additional credit card fees may be billed as well, from time to time, as determined by the practice that are not refundable.

It is your responsibility to keep up with your patient account. You will receive (or have access to) explanation of benefits (EOBs) from your insurance company. These reports are not bills, but provide you with general information regarding what you owe us. Non-covered services and administrative service fees that you are responsible for will not be shown on EOBs.

PLEASE PROVIDE US WITH YOUR EMAIL ADDRESSE(S) WHERE YOU WOULD LIKE US TO SEND YOUR BILLING STATEMENTS.

_____@_____._____

_____@_____._____

_____ _____
Name (Printed) Signature

_____ _____
Date Account Number (Completed by office)