Dan Purser MD

NATURAL AND MODERN

Patient Medication/Complication Questionnaire

Please fill out & email to info@danpursermd.com before your appointment

1. What current medications are you taking?

(Antacids, allergy medications, NSAIDS, heart medications, etc…)

Please list here:

2. What diseases or afflictions do you currently treat? And what allergies to be aware of?

(Comorbidities such as: diabetes, cardiovascular or respiratory conditions, immunocompromising diseases)

Please list here:

3. What OTCs (Over The Counter medications or supplements — like antacids) do you take?

Please list here:

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Registration Form

Today's Date: _____

Last Name: _____ **First Name:** _____ **Middle Initial:** ____

DOB: _____ **Gender:** ____ **Primary Care Physician:** _____

Home Address: _____ **City, State, Zip:** _____

Phone: _____ **Phone 2 (Optional):** _____ ☐ **Preferred Contact**

Email: _____ **Email 2 (Optional):** _____ ☐ **Preferred Contact**

Would you like to be included in Dr. Purser's email list? ☐ **Yes** ☐ **No**

Occupation: _____ **Marital Status:** _____ **How did you hear about us?** _____

Friends or family members seen: _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

_____ _____

Patient (Guardian) Signature Approval for Treatment **Date**

Privacy of Medical Records

The Department of Health and Human Services has established a 'Privacy Rule' to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

- As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide to health care that is in your best interest.
- We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, of health care operations. These entities are most often no required to obtain patient consent.
- You may refuse to consent to the use or disclosure or your personal health information, but this must be in writing. Under this law, we have the right to refuse treatment should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review the privacy notice, to request restrictions, and revoke consent in writing after you have reviewed the privacy notice. Thank you for taking the time to read and understand these policies. Your signature below represents an understanding of these policies and acceptance of the Privacy Rule.

_____ _____

Patient (Guardian) Signature **Date**

Private Contract with Insurance or Medicare Beneficiary

This agreement is between Dan Purser, MD ("Physician"), whose principal place of business is Dan Purser MD, pllc, and patient _____ ("Patient"), who resides at _____ (Address) _____ (City, State, Zip) and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997 *or any other federal or state insurance program*. Physician has informed Patient that Physician has opted out or is not a participator in the Medicare or any federal/state insurance program for a period of at least two years and is excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 and other sections of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Evaluation & Management, Consultation and Professional Component Services. In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Practice Fee Schedule. Patient also agrees, understands, and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that MediGap or secondary plans will not provide payment or reimbursement because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
- Patient agrees to be responsible to make payment in full for the Services and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that their insurance or Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him or her.
- Patient agrees to reimburse Physician for any costs and reasonable attorney fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ (Date) by _____ (Patient Name) and _____

_____ (Physician Name).

_____

Patient Signature

_____

_ Physician Signature

Medicare/Medicaid Advisory

The undersigned hereby acknowledges that they have been advised and understand that Dr. Danny C. Purser, MD is not a participating physician for either Medicare or Medicaid, and does not submit billings for services to or accept payment from either program. They further understand that in as much as Dr. Purser is not a participant, prescriptions issued by him should not be submitted for payment under either of the said programs, as doing so will most likely result in a denial of payment or reimbursement.

_____

Print Name **Signature (Patient or Representative)** **Date**

Cancellation Policy

Late Cancellation & No-Show

We understand you may need to cancel your appointment. If so, one business day before the start of your appointment is required (e.g. appointment scheduled on Monday at 2pm must be cancelled before Friday at 2pm). Late cancellations will be considered a no-show and subject to a 50% fee of the booked consultation amount.

_____ _____

Patient (Guardian) Signature **Date**