Dear Prospective Patient:

*Please fill out completely & return packet to our office
*We will review and call you if you are accepted as our patient

This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you will find this information useful.

Geemson Oo, MD PLLC is a private practice with a single physician.

Our office hours are:

Monday	9:00 – 5:45
Tuesday	9:00 - 5:45
Wednesday	9:00 – 1:45
Thursday	9:00 - 4:30
Friday	9:00 – 5:00

Our office phone number is 716-712-0920 and fax is 716-712-0922. In the event of an emergency outside of our normal business hours patients may call the office and the answering service will contact the doctor on call for you, however, please note in case of immediate emergencies dial 911.

At Geemson Oo, MD PLLC we practice preventative medicine as well as caring for your chronic and acute medical needs. Our practice philosophy is to try for early detection, early intervention and prevention. Regularly scheduled office visits allow us to better assist you in identifying and managing any chronic health problems you may have. We believe this is in your short and long-term best interest.

Being proactive about our health care can often help us prevent and/or prolong the onset of future health problems as we age. We firmly believe, and our experience has shown it to be true, that those patients who are consistent in keeping their appointments have fewer episodes of acute illness, difficulty with unstable chronic illnesses, and generally continue to enjoy better health overall.

We provide friendly reminder calls that you receive 48 hours in advance of your appointment. We do understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we do request you extend us the courtesy of a 24-hour notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that if you miss your appointment there is a fee that the practice charges, please reference the No Show Policy.

For the benefit of our patients we are contracted with several insurance carriers as a provider. You will want to check your benefits booklet or with the benefits department of your employer to verify if Dr. Geemson Oo is listed as a provider within your network. As part of our contract with the insurance companies we are legally required

by the terms of the contract to collect any co-pays or deductibles from you at the time of service. We do ask that you be prepared to pay your co-pay at the time of check in and your account may be assessed a $5 charge if payment is not received. Failure on our part to collect these monies can result in cancellation of our provider contract. Patients who do not have insurance coverage will be expected to pay at the time of service. A $60 deposit will be collected before seeing the physician. Your balance will be reconciled at the time of checkout. We do offer a 25% discount for same day payment of services. For your convenience we accept Cash, Check, and Credit Card, however, there is a $35 returned check fee, for any check returned.

It is our desire to have a mutually respectful relationship with our patients. As part of the relationship we expect our patients to maintain a good credit rating with our office. Failure to pay for medical services delivered in good faith will cause a patient's account to be turned over to an outside agency for collection. Should collection proceedings be required to collect an outstanding debt you will be responsible for all additional expenses incurred to collect the debt including the collection agency fees and any associated court costs. Should this become necessary you will also be discharged from the practice. If you should ever decide to file for bankruptcy proceedings against an outstanding debt owed to Geemson Oo, MD PLLC it is the policy of our practice to withdraw as a health care provider giving legally required notice.

If you have any questions or need further clarification of our practice philosophy or our policies, please do not hesitate to contact our office for assistance.

In a sincere effort to maintain patient satisfaction while honoring the need to maximize effectiveness and efficiency of our work processes, we have implemented procedures which we hope will let us provide you with the best quality medical care we can.

If you have tests ordered or blood work drawn at our office we will contact you for a follow up appointment with us after your tests results are received. If you have any concerns after you've had the tests done and we have not contacted you, please call us.

Please make a complete list of all medications that you are currently taking and bring it with you to your first visit. For all subsequent visits we will provide you with a current list of medications for your review at each follow up visit. Our front office staff will also review your demographic and insurance information with you at each visit to ensure that we maintain your correct information on file. This allows us to be able to submit your claim to insurance in a timely manner.

Please evaluate your medication supply prior to your office visits and try to correlate all refills with your scheduled appointments. Should refills be requested after a visit they will only be authorized if the physician determines there is an extenuating circumstance warranting a refill outside of the timeframe of a scheduled office visit. In those

situations the refill will only be performed during normal office hours and will require a 48 hour turn around time. When you call please have the following information ready: patient name and date of birth; prescription name and number; pharmacy name and telephone number. Please check at the pharmacy after 48 hours-do not recall our office. We will only call you back if there is a problem with refilling your request. If you utilize a mail in pharmacy we will write the prescription, but it becomes your responsibility to mail it in.

Please allow 5-7 working days for the completion of any forms, prior authorizations, or letters. Please be aware that any form brought by to be completed may need a visit.

There is a standard fee for any form completion including FMLA. This amount is per form and based on the number of pages per form. This amount is due at the time the forms are submitted to our office. We do not charge for prior authorizations.

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission.

There may be times when you may request that we provide copies of our records on you to other entities. We do incur an expense to provide you with this service and that cost will be passed on to you. Our fee for copies is per New York State law we charge the reasonable cost-based fee of $0.75 per page plus the approximate cost of postage for providing the medical records to patients, lawyers and all other outside parties' requests. If the cost for the copies is not reimbursed by the receiving entity that you have authorized to obtain these records you will be responsible for payment before the records can be released.

Lastly, Dr. Oo refers **all** Pain Management out to physicians that specialize in that area; he does not maintain or manage pain medication for his patients. He does not prescribe controlled substances to his patients for their Pain Management however he is very happy to refer his patients to a specialist who are experts in Pain Management.

Thank you for allowing us to assist you with your health care needs.

Sincerely,

Geemson Oo, MD PLLC

PATIENT DEMOGRAPHIC FORM

Patient Name: _____
Patient's Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____
SEX: M ___ F _____ Marital Status: S __ M __ D __ W __

Street Address: _____ Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (_____) _____ Work phone: (_____)_____
Cell/Pager number: (_____) _____ Email Address: _____
Emergency Contact Name: _____ Emer. Contact Phone: (_____)_____
Race: ____White ___Black ___American Indian ___Asian ___ Native Hawaiian/Pacific Islander ___Other
Ethnicity: __Spanish/Hispanic __Not of Spanish/Hispanic origin Primary Language: _____

Responsible Party Name: _____
(Last) (First) (Middle)
Relationship to Patient: _____ Responsible Party Date of Birth: _____
Guarantor's Social Security Number: _____ - _____ - _____
Guarantor's Address: _____Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (_____) _____ Cell/Pager number: (_____) _____
Employer's Name: _____ Work Phone: (_____) _____
Employer's Address: _____
City: _____ State _____ Zip Code: _____

**** PLEASE NOTE WE DO NOT ACCEPT WORKMAN COMPENSATION CLAIMS****

Primary Insurance Company's Name: _____

Insurance Address: (Back of card Claim Address)
_____
City: _____ State _____ Zip Code: _____
Phone Number (_____) _____
Name of Policy Holder: _____Date of Birth: _____
Insurance ID Number: _____ Group Number: _____
Secondary Insurance Company's Name: _____
Insurance Address: _____
City: _____ State _____ Zip Code: _____
Phone number (_____) _____
Name of Policy Holder: _____Date of Birth: _____
Insurance ID Number: _____Group Number: _____
(If you have a third insurance please notify receptionist)

Previous PCP – *If applicable*
Name _____ Phone (____) _____
Address _____City _____ State _____ Zip _____

Please Read and Sign:
I hereby authorize my insurance benefits to be paid directly to Geemson Oo, M.D. I understand and am responsible for all charges including my added costs incurred due to any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.
Signature of Responsible Party: _____ Date: _____

Referred by: _____

Geemson Oo, MD
716-712-0920

PATIENT HISTORY FORM

Your Name: _____ Date of Birth: _____

Date you are filling out this form: _____

What type of complaint or disease is the reason for requesting this visit? _____
_____

TELL US ABOUT YOURSELF:
Home situation (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership_____ Children?_____ Are they healthy?_____

Employment:
Status: Full-time_____ Part-time_____ Retired_____ Disabled_____ Homemaker_____

Occupation/type of work/jobs:_____

Place of Employment: _____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____
Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

PAST MEDICAL HISTORY:
Please list other diseases from which you <u>currently</u> suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

_____

_____

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

SYMPTOM REVIEW

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ abnormal Pap smear
- ☐ bleeding between periods
- date of last mammogram_____

Men only
- ☐ PSA

Anything else?
- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: if YES, give approximate year given

Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____

Do you use seatbelts? No_____ Yes_____

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When?_____

Patient: _____ ***DOB:*** _____

Geemson Oo, MD
3775 Seneca Street, West Seneca, NY 14224
Tel: 716-712-0920 Fax: 716-712-0922

STATEMENTS OF AUTHORIZATION

STATEMENT TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS

I authorize the release of my medical information necessary to process any submitted claim by the office of Dr. Oo. I also authorize payment of medical benefits to the above named physician for services provided to me.

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for payment under title XVII of the Social Act is correct. I authorize any holder of medical information about me released to the Social Security Administration, or its carriers, and information required to process my Medicare Claims. I request that payment under the medical insurance program be made either to me or for services provided to me.

NO FAULT/WORKERS' COMPENSATION CLAIMS

I understand that if I have requested treatment from Dr. Oo under a No Fault claim and my claim is denied I am responsible for payment for any and all treatment rendered. I also understand that Dr. Oo is not a participating physician for Workers' Compensation; therefore any claim rendered and denied I am responsible for payment for any and all treatment rendered.

STATEMENT OF MEDICAL RELEASE

I authorize the release of my medical information to other physicians whom I am under the care of (referred physicians, specialists, etc). I understand that there is a charge for records requested in accordance with the NY State law.

STATEMENT OF ACCOUNT

I understand that if I have issued a personal or business check to pay for my cost of services rendered and it is returned to Dr. Oo for any reason that it is not cashable by the bank, I am responsible for the face value of this check and a service charge of an additional $35.00. I understand that any balances I owe are more than 90 days past due will be given to an agency of collection with an additional $30 per the Copay and Collections Policy and I must correspond with this collection agency directly.

I understand that I am responsible for payment of the required insurance co-payment at the time of my visit. If I request to be billed the co-payment, I understand that there will be an additional $5.00 fee added to the co-payment.

I understand that there will be a fee of $30- $75.00 (depending on appointment type) for an appointment that I do not give at least 24 hours notice for cancellation or fail to keep my appointment.

By signing below I acknowledge that I have read and understand the above authorizations and consent to their contents and intentions.

Signature _____ *Date* _____

Geemson Oo, MD, PLLC
3775 Seneca Street
West Seneca, NY 14224
Effective 2011

New Patient Controlled Substances Policy

The purpose of this agreement is to protect your access to controlled substances and to protect our practice.The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, andbarbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-termbenefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person witha 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 acondition of, the willingness of the physician whose signature appears below.

1. Dr. Oo will not prescribe any controlled substances for any new patients that have not been established with our practice.
2. New patients will be required to complete drug testing.
3. All controlled substances must be obtained at the same pharmacy, where possible.
4. 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.
5. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
6. You may not share, sell, or otherwise permit others to have access to these medications.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence 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 otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or 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. 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 Physician Name (Printed) Date

_____ _____ _____

Patient Signature Patient Name (Printed) Date

Geemson Oo, M.D., PLLC

Financial Policy

Welcome to Geemson Oo, M.D., PLLC. In order for our medical staff to be able to deliver the quality of care that you are accustomed to; we have established financial policies. Below is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, it is your responsibility to notify the receptionist.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash and/or checks. **If a co-payment is not made at time of service, there will be a $5.00 "billing fee" charged to your account for the processing and mailing of a statement**.
4. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
5. If your insurance denies our charges, does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and be reported to the credit bureau.
6. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of services. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
7. HMO-PPO PATIENTS: We will bill your insurance for you. Your co-payment will be collected at the time of service-no exceptions.
8. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full; you must contact our billing department prior to seeing the doctor to make payment arrangements.
9. No show or missed appointments: When an appointment is scheduled with the doctor and/or nurse, time is specifically allocated for you. When an appointment is not canceled in advance (24 hours), the appointment is considered to be a "No Shows". We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If *two* appointments are missed without cancellation, you will be charged a fee. **New patient $75; Follow-up $30.**

   If *three* appointments are missed, you will be possibly dismissed from the practice for non-compliance.
10. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanations should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.
11. If your account is transferred to a collection agency there will be a 33% collection fee added to your account.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (716) 242-8240.

I have read and have a full understanding of Geemson Oo, MD, LLC's Financial Policy

Signature _____ Date _____

GEEMSON OO, MD, PLLC
Authorization for Use and Disclosure of Protected Health Information

This form provides authorization to **GEEMSON OO, MD, PLLC** ("the Practice") to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, _____,(date of birth: _____) authorize the Practice to ***(choose one)***: ❑disclose to ***(name of doctor records are to be sent to)***
☒ obtain from: ***(name of Previous doctors and specialists)***

Doctor's Name _____
With an address at: _____
_____
_____

The following information:
_____
_____
_____
The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization. I understand that if my records contain information about alcohol and drug abuse, mental health treatment and/or HIV/AIDS status, I authorize the Practice to release such information as part of my medical record only if I place my initials on the appropriate line as set forth below.

Included in information to be released:
____ Alcohol/Drug Treatment
____ Mental Health Information
____ HIV Related Information

Purpose of Information to be Disclosed [If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose, the purpose shall be stated as "at the request of the individual"]**:**_____
_____

This authorization shall expire upon the earlier of (i) ____ days from the date of this request or (ii) the following date _____ or (iii) the occurrence of the following:
_____.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer, at **Geemson Oo, MD, PLLC**.
3775 Seneca Street, West Seneca, NY 14224. Phone 716-712-0920, Fax 716-712-0922

I understand that a revocation is not effective to the extent that the Practice has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that the Practice will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority