Mary Y. Tang, MD
Concierge Mobile M.D.
1527 State Hwy 114 West, Suite 500-125
Grapevine, TX 76051
682-223-1526; 817-382-5390 (fax)
conciergemobilemd@gmail.com

WELCOME

Thank you for choosing Dr. Mary Tang as your primary care physician. Dr. Tang will strive to meet all of your needs and answer any questions you may have, while providing a higher standard of care in the comfort of your own home. We welcome you as a new patient, and we would like you to take a moment to get acquainted with Dr. Tang's practices and policies.

The doctor's office hours are from 9 am to 5 pm, Monday through Friday. If you have questions or need assistance, please call our office at **682-223-1526**. During office hours, your call will be answered by a member of Dr. Tang's staff. Urgent messages left after office hours will be returned by Dr. Tang as soon as possible.

During an emergency, call 911 first. You do not need to call Dr. Tang to get permission to go the Emergency Room(ER). Should you need to go to the ER for any reason, know that Dr. Tang does not require you to go to a specific hospital. She keeps in contact with physicians at local hospitals in order to stay updated about her patients' care. When you arrive at the ER, if admission is needed, please inform the ER staff to call Dr. Tang.

Please be aware that all standard co-pays are due at the time of the visit. If you do not have a secondary insurance, you will be responsible for the 20% co-insurance that Medicare does not pay as part of their allowable charge. If you have any questions about this policy, please contact our office.

Dr. Tang usually sees patients for routine visits approximately every 4-6 weeks. This may vary depending on the patient's needs. You do not need to call to schedule your routine visits. Dr. Tang's staff will call to notify you when she will be coming to see you. If you think you need a visit sooner for an urgent problem, please call the office. Patients must have been seen within the previous six months in order to have Dr. Tang continue to refill their medications.

When you need to refill a prescription, please call your pharmacy first to find out if they already have refills for you. If you do not have any refills available, ask your pharmacist to contact our office or have them fax us a prescription renewal request. If, for any reason, they are not able to accommodate you or you have

additional questions, feel free to contact a member of Dr. Tang's staff during normal business hours. Please give 3 days' notice for any refills you need at a local pharmacy, and at least one week notice for a mail-in pharmacy to ensure you don't run out of your medications.

If you are ever referred to a specialist or choose to see another physician for any reason, please notify our office. This will allow us to keep our records current and be aware of any medication changes that may have occurred. It is very important that both the specialist and Dr. Tang are aware of any changes that have occurred in your care to ensure that there are no adverse medication interactions. This includes any hospital stays or surgeries that may be necessary. Additionally, please ask any specialists you see to forward a copy of their consult notes to our office so that Dr. Tang is aware of any changes they have made or tests ordered.

Thank you for taking the time to read this letter. If you have any questions or concerns, you may contact us at **682-223-1526 or conciergemobilemd@gmail.com.** We wish you good health and happiness, and we welcome you to the practice.

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PATIENT INFORMATION FORM

Leaving any fields blank will delay the processing of your request.

PERSONAL INFORMATION

Patient's Full Name:_____
(LAST) (MI) (FIRST)

Date of Birth____/____/_____ Sex (circle one) M / F
mm dd yyyy

Race (please circle): White Black Hispanic Asian

American Indian/ Alaska Native Native Hawaiian/ Pacific Islander Other

Home Phone _____ Cell Phone _____

Email: _____ Preferred Language: _____

Address or Name of Assisted Living Facility:

_____

City, State, Zip: _____

INSURANCE INFORMATION

Is patient covered by Medicare (circle one) YES / NO

Medicare Number_____

What is patient's secondary insurance (if applicable)_____

Policy or ID Number:_____

Group Number_____

Customer Service Phone Number: (on back of card)_____

*******PLEASE EMAIL, FAX, OR MAIL COPIES OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARDS.*******
(Enlarged copies would be appreciated.)

TO WHOM SHOULD BILLS BE SENT?(circle one) PATIENT / OTHER

If other, please provide:

Full Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email: _____ Relationship to Patient:_____

EMERGENCY CONTACT

Name/Address of relative or friend not living at same address

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Email: _____

Cell Phone:_____ (circle one) voice mail / text

If you do not object to text messages, name of wireless carrier: _____

Relationship to Patient:_____

APPOINTMENT CONTACT

Person to Contact: _____

Preferred contact method(complete one):

Home phone:_____

Cell phone:_____ (circle one) voice mail / text

If you do not object to text messages, name of wireless carrier: _____

Email:_____

Preferred* appointment time (circle one): 10am-1pm 1pm-4pm 4pm-7pm

*Please note it may not always be possible to schedule your appointment during the preferred time.

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RECORD RELEASE FORM

DATE: _____

TO: _____

FAX #: _____

Please release my medical records to Dr. Tang at the above address. Dr. Mary Tang is the Primary Care Physician for this patient and records are needed for the continuity care. Please release records via fax or thru the eClinicalWorks EHR.

___Hospital Chart Dated _____(Please include all dictated reports, labs, and x-rays. Please do not send handwritten notes other than ER notes.)

___ Office Chart (Most recent progress note, most recent labs, recent x-rays, any CT or MRI)

___ Other: _____

___ Other: _____

___ Other: _____

Thank you.

Sincerely,

- -

COMPLETE INFORMATION BELOW LINE.

X_____
SIGNATURE

Please circle: PATIENT or Patient Representative

PRINTED NAME OF PATIENT_____

PATIENT'S DOB_____

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NOTICE OF PRIVACY PRACTICES (4/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose your confidential health information to other persons or entities. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider with whom we need to consult in respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you.

This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or reviewal of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
PRIVACY OFFICER, PO Box 1473, Grapevine, TX 76099

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS (3/03)

I consent to the use or disclosure of my protected health information by Dr. Tang for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Tang. I understand that analysis, diagnosis or treatment of me by Dr. Tang may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Tang is not required to agree to the restrictions that I may request. However, if Dr. Tang agrees to a restriction that I request, the restriction is binding on Dr. Tang.
I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Tang has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Dr. Tang. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Tang. This Notice of Privacy Practices also describes my rights and the duties of Dr. Tang with respect to my protected health information.

Dr. Tang reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Dr. Tang and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative **Printed Name of Patient**

_____ _____

Date of Signing **Description of Personal Representative's Authority**

Please Circle: Patient or Patient Representative

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FINANCIAL RESPONSIBILITY

- I understand that Dr. Tang accepts Medicare assignment. This means that she accepts Medicare's allowed amount as payment for services. Because Medicare only pays 80% of that allowed amount. I understand that I will be responsible for the remaining 20%. If I have secondary insurance, Dr. Tang will bill my secondary for this 20%. However, if for any reason my secondary does not pay, I will be responsible for the 20%.

- I understand that Dr. Tang does not accept Medicare HMO's and that I will be financially responsible for payment of services if Medicare denies payment due to my participation in an HMO program. I will also be responsible for payment if I choose to cancel Medicare Part B coverage.

- I further understand that Dr. Tang will not schedule new patients until insurance is verified.

- It is my responsibility to notify Dr. Tang of any changes in my insurance.

- I hereby assign Dr. Tang any money payable to me under my insurance coverage, and/or other arrangements with third parties, for payment of such services. I also agree to be financially responsible for any testing or treatment that may not be considered by my insurance company to be medically necessary.

- If the patient does not have a secondary/supplemental insurance, the 20% co-insurance is due at the time of the visit, payable by cash or check only. Returned checks will be charged a $35 fee.

- I further understand that Medicare allows the physician to bill for Chronic Care Management and/or Care Plan Oversight between visits every month. This includes telephone management/consultation and coordination of services with home health agencies and other healthcare providers. I understand that Medicare will pay for 80% of these services. If my secondary insurance does not cover the 20% for these services, I will be responsible for the 20%.

- I understand that Dr. Tang's office reserves the right to charge $50 for any appointments cancelled with less than 24 hours' notice.

- This agreement will be retroactive to October 2018 for all patients.

Patient or Patient Representative Signature **Printed Name** **Date**

Patient Name (if signed by Patient Representative)

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name_____

1. I DO_____DO NOT_____ authorize Dr. Tang and her staff to use email to communicate with **me** regarding my medical issues. I understand emails are not HIPAA compliant and that the information contained in the email is not guaranteed to remain private.

   I DO_____DO NOT_____ authorize Dr. Tang and her staff to use email to communicate with **my family member(s) listed below** regarding my medical issues. I understand emails are not HIPAA compliant and that the information contained in the email is not guaranteed to remain private.

If I do authorize the use of email, I release Dr. Mary Tang and staff from any liability of breach of privacy that may result from the use of email communications.

2. I authorize Dr. Tang and staff to speak to the following family members regarding any and all issues relating to my health:

_____ Email: _____

_____ Email: _____

I do NOT authorize Dr. Tang and her staff to speak to the following family members regarding any and all issues relating to my health:

_____ _____

3. My medical power of attorney is_____

4. My financial power of attorney is_____

5. If the patient resides at an assisted living facility, the patient authorizes Dr. Tang and her staff to discuss any and all issues of medical care in regards to the patient with the staff at the facility who are involved with his/her care. The patient will hold Dr. Tang and staff harmless for any breach of privacy issues related to these discussions. _____
   (Initial here)

_____ _____

Signature of Patient or Patient Representative **Date**

_____

Printed name of Patient or Patient Representative

Please Circle: Patient or Patient Representative

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AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize Dr. Mary Tang and her staff to obtain my prescription history of prescription medications that I have obtained through other physicians while I am under her care. I understand that this information will help Dr. Tang to provide better care and to avoid prescribing medications that may interact with medications prescribed by other physicians. Further, I promise to disclose to Dr. Tang of any medication changes at each visit, or to notify her office between visits if I have obtained new prescriptions from other doctors.

Patient's Signature Date

If not the patient please print name of person signing for the patient and if he/she is the POA