FINANCIAL POLICY

ANGELA BULLY, M.D.
TAMMIE L. BULLY, M.D.

Patient Name: _____

Date of Birth: _____

Thank you for choosing Dr. Bully as your health care provider. We are committed to your treatment being of the highest quality. As part of the provider/patient relationship, we believe that it important for you to understand the Financial Policy regarding payment for services. We ask that you review and sign this policy prior to any treatment.

Regarding Insurance Coverage

Dr. Bully serves as participating provider with Blue Cross and Blue Shield of Michigan, Medicare and Medicaid, as well as a select group of other insurance companies.

For those companies with whom Dr. Bully does not participate, payment for services at the time of your visit is your responsibility. **Please confirm whether your insurance is accepted before being seen.**

The balance of all visits/treatment is your responsibility whether your insurance company pays or not. In order to bill your insurance it is necessary for you to bring all insurance information. As a courtesy, we will bill your insurance company. If your insurance company has not paid your account in full within 90 days, we will contact you regarding recovery of the amount owed.

If your insurance coverage is with an HMO or other Managed Care Program, we will bill them for you only if you present an authorization for services from them. You are still responsible for payment of deductibles, co-pays, and non-covered services. If you do not have an authorization for each visit and /or treatment, the responsibility for payment will be yours and must be paid at the time of service.

Adult Patients

Adult patients are responsible for the entire amount not covered by insurance.

Minors

The parent(s) or guardian(s) of a minor will be responsible for entire amount not covered by insurance.

Credit Risk

I understand that should I default on payment for services, then my account may be transferred to an independent collection agency, designated as a CREDIT RISK and that payment for services at the time of registration will be required for all future visits.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

X_____ DATE: _____
Signature – Patient / Responsible Party

X_____ DATE: _____
Signature – Co-Responsible Party

General Consent Form

Angela Bully, M.D. **Tammie L. Bully, M.D.**

Patient Name _____ Date _____

Last 4 Numbers of Social Security_____ D.O.B. _____

1. I hereby do voluntarily consent to such care including routine procedures, examinations tests, immunizations, vaccinations, regional or local anesthesia and other treatment by Dr. Bully or her assistants as is necessary in their judgment.

2. If I don't fully understand a procedure or its risk, consequences and alternate methods of treatment, I have the right to question the appropriate health care professional.

3. I realize that Dr. Bully's practice site may include teaching medical students and that some procedures may be performed by students under the supervision of Dr. Bully.

4. I understand that blood may be drawn from me for HIV testing without further permission being given by me if a doctor, or other health professional or employee is exposed to my blood or bodily fluids.

5. I understand that Dr. Bully shall not be responsible or liable for the loss of/or damage to any personal property.

6. I authorize the release to Dr. Bully such information from my records as is required in order for Dr. Bully and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and /or treatment, records indicating testing, diagnosis or treatment of HIV infections, or any other related condition, records of psychological services and social services, including communications made by the patient to the physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

7. I authorize Dr. Bully to review my insurance coverage with my insurance company.

8. I authorize payment of insurance benefits to be made directly to Dr. Bully.

9. I permit a copy of this authorization to be used in place of the original if necessary.

I have read this form and my questions have been adequately answered and I certify that I understand its contents.

SIGNATURE OF PATIENT: _____

SIGNATURE OF WITNESS: _____

SIGNATURE OF PARENT OR GUARDIAN: _____

MEDICATION LIST (Continued)

Name of Medication	Strength (mg)	Taken How

Do you know what Advanced Directives are? Yes No
If Yes, do you have Advanced Directives? Yes No
If No, would you like information about Advanced Directives Yes No

Patient Signature/Date _____

Physician Signature/Date _____

HEALTH HISTORY

Patient Name: **DOB:**

Please circle medical diagnosis that apply for both yourself and your family and indicate on the line which family member it applies to (Including the deceased).

	PATIENT		FAMILY	Which family member
*Anemia	no	yes	yes	_____
*Arthritis	no	yes	yes	_____
*Asthma or Emphysema	no	yes	yes	_____
*Cancer (type or location)	no	yes	yes	_____
*Chronic Headaches	no	yes	yes	_____
*Diabetes	no	yes	yes	_____
*Gastritis or Ulcers	no	yes	yes	_____
*Heart Disease/Murmurs	no	yes	yes	_____
*High Blood Pressure	no	yes	yes	_____
*High Cholesterol	no	yes	yes	_____
*Kidney Failure/Stones	no	yes	yes	_____
*Liver Disease/Alcoholism	no	yes	yes	_____
*Psychiatric Disorders	no	yes	yes	_____
*Sinusitis	no	yes	yes	_____
*Strokes or Seizures	no	yes	yes	_____
*Thyroid Disease	no	yes	yes	_____
*Disease not mentioned				_____
				_____

Please list **any Surgeries** you have had in the past with the approximate date.

Please list **any Hospitalizations** with the approximate date and hospital name (if known)

Please list **all Medications** you are taking (include over counter), and **pharmacy name &phone number**(use reverse side if necessary)

Please list any **Medication Allergies**

If you have ever **smoked tobacco or drink alcohol**, please indicate how much you smoke and for how long, how much you drink, what type, and how often.

REGISTRATION INFORMATION
INTERNAL MEDICINE

ANGELA BULLY, M.D. TAMMIE L. BULLY, M.D.

Date_____

Cell # (___)_____ Home # (____) _____ Work # (_____) _____

Patient: _____
Last Name First M.I

Sex: □ M □ F Age:_____ Birthdate:_____-_____-_____ Last 4 of Soc Sec # _____

Address:_____ City/State:_____ Zip:_____

Emergency Contact Information

Name:_____

Relationship:_____ Phone (_____)_____

Primary Insurance

Contract Holders:_____ Date of Birth_____
Last Name First Name M.I.

Relationship to Patient:_____ Employer:_____

Insurance Company :_____ Phone(_____)_____

Address_____ City, State_____ Zip_____

Contract Number:_____ Group Number_____

Effective Date_____ Cancellation Date:_____

Source of Verification (See Attached Copy)_____
204(Driver's License, Social Security Card, or Insurance Card)

IF YOU HAVE MORE THAN ONE COMMERCIAL INSURANCE PLEASE SEE THE RECEPTIONIST FOR AN ADDITIONAL FORM.

COMMERCIAL AUTHORIZATION

I certify that to the best of my knowledge the above information is correct. I authorize Dr Bully to review my insurance coverage with my insurance company as indicated above. I authorize any holder of medical information to release medical and other information to my insurance company for review of my coverage and/or for processing of claims for services rendered to me. I further authorize the release to Dr. Bully of such information as may be necessary for these purposes by my insurance company.
I hereby authorize you to pay directly to the below named doctor benefits due me out of my indemnity under the terms of my policy issued by your company.

Angela Bully, M.D., P.L.L.C.

Payment is authorized upon your receipt of itemized statement for services rendered. Payment of this amount as herein directed, in whole or in part, shall be considered the same as if paid by your company directly to me. I permit a copy of this authorization to be used in place of the original.

Signed_____ Date_____
(If insured is a minor, parent or guardian must sign)

Signature of Person Completing Form_____ Date_____

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 QUESTION ABOUT THIS NOTICE, PLEASE CONTACT YOUR PHYSICIAN.

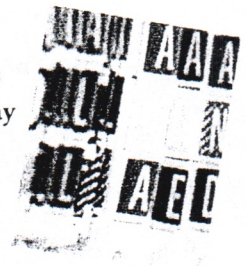
Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

(1) make sure that medical information that identifies you is kept private;
(2) give you this Notice or our legal duties and privacy practices with respect to medical information about you; and
(3) follow the terms of the Notice that is currently in effect.

How This Office May Use and Disclose Your Medical Information



The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the way we are permitted to use and disclose your medical information will fit within one of these general categories.

For Treatment. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all patients who receive treatment at this office may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identified you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health recovery of all patients who received one medication to those who received another for the same condition.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Worker's Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence and adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement. We may release medical information about you if required by law when asked to do so by a law enforcement official.

Coroners and Medical Examiners. We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Your Rights Regarding Your Medical Information:

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact your physician.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask is to amend the information. You have the right to request an amendment for as long as the information is kept by this office.

To request an amendment, your request must be made in writing and submitted to your physician. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

(a) Was not created by us;
(b) Is not part of the medical information kept by this office;
(c) Is not part of the information which you would be permitted to inspect and copy; or
(d) Is not accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures that office has made of your medical information.

To request this accounting of disclosure, you must submit your request in writing to your physician. Your request must state a time and person which may not be longer than six years and may not be dated before February 26, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use and disclosure we make of your medical information.

We are not required to agree to your requests for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to your physician.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to your physician. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. 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 website if available.

To obtain a paper copy of this Notice, contact your physician.

Revisions to This Notice

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you visit the office we will offer you a copy of the current Notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health, and Human Services. To file a complaint with this office, contact your physician. This should be the same person or department listed on the first page as the contact for more information about this Notice. All complaints must be submitted in writing.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Other Uses of Medical Information

Other uses and disclosures of your medical information not covered by this Notice of Private Practices will be made only with your written authorization. If you provide us such authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

NOTICE OF PRIVACY PRACTICES

ANGELA BULLY, M.D.

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.

Our Promise To You, Our Patients

Your information is confidential.

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Effective April 14, 2003.

Dear New Patient,

The purpose of this letter is to introduce you to our practice and extend a warm welcome as we help you prepare for your upcoming visit. As a Family business, our motto is "Family Treating Families". Our hope is to make a lasting impression so that you will feel comfortable not only with the care you receive but would have no problem referring your family and or friends to our practice.

In preparation for you upcoming visit and to help expedite your registration, please make sure to bring all the necessary documents. To register as a new patient you will need a photo ID, insurance card(s), any applicable insurance copayments, and prior physician(s) address and phone number(s) if you are transferring your care from another practice and or have important medical documents that we need to obtain. It is very important that you bring accurate information regarding the medication you are currently taking. Please bring either your medication bottles or a list (with medication dosages) of what you take, along with your pharmacy information. Please note, if you are in need of a narcotic medication you **must** bring medical records with you verifying history of the medical reason for a narcotic drug before refills can be given.

Although we are a busy Primary Care practice, we pride ourselves on efforts to accommodate new patients at short notice and never overbook our appointment slots. In order to do this we need full cooperation from all patients. When patients neglect to cancel their appointments other patients can't get in to be seen. Thus, we ask that if you are unable to keep your scheduled appointment please call our office as soon as possible. You may leave this information on our voicemail 24 hours a day. Otherwise, you should receive an automated appointment confirmation call from New Jersey phone number 732-873-5133 48 hours before your scheduled appointment.

We eagerly look forward to meeting and providing you with long term quality medical care.

Sincerely,

Angela Bully, MD

Tammie Bully, MD