Stuart Lerner, M.D.
970 N. Kalaheo Ave., Suite 316
Kailua, Hawaii 96734

P: 808.954.4463
F: 888.364.2014
www.dr-lerner.com

Patient Registration Information

Patient Information

____ _______/_______/______ □Male □Female
Last Name, First Name | Date of Birth

______-______-______ ____________________ ____________________ ____________________
Social Security No. | Home Phone | Cell Phone | Work Phone

____ ____
E-Mail Address | Primary Care Provider

____
Home Address, City, State, Zip Code

____
Billing Address, City, State, Zip Code (If different from above)

____________________ ____________________ ____________________ □ Prefer not to answer
Preferred Language | Race/Ethnicity | Marital Status

In Case of Emergency

______________________________ ______________________________ ____________________
Emergency Contact Name | Relationship | Phone Number

Consent to Treat Minors (Only for patients under 18 years old)
I authorize Dr. Stuart Lerner to provide medical treatment to my child, the patient mentioned above.

My child may: □ receive treatment when I am not present. □ not receive treatment, unless I am present.

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Aloha!

Thank you for choosing Dr. Stuart Lerner as your primary care provider. We are committed to partnering with you to help you achieve the best health that you can. Dr. Stuart Lerner is a designated "patient centered medical home" practice. This means that we will provide you with an expanded type of care. We will work with you and any other health care providers that you may have as a team. You will have access to your health information via an on-line portal. You will be able to communicate securely online with our staff via this portal.

As your primary care provider, I will:

- Learn about you, your family, life situation, and health goals and preferences. I will remember these and your health history every time you seek care and suggest treatments that make sense for you.
- Take care of any short-term illness, long-term chronic disease, and your all-around well-being.
- Keep you up-to-date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. I will respond promptly to you in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy

We trust you, as our patient, to:

- Know that you are a full partner with us in your care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using, and questions you may have.
- Let us know when you see other health care providers so we can help coordinate the best care for you.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition, ask questions about your care, and tell us when you don't understand something.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within two weeks.
- Contact us after hours only if your issue cannot wait until the next work day.
- If possible, contact us before going to the emergency room so someone who knows your medical history can care for you.
- Agree that all health care providers in your care team will receive all information related to your health care.
- Learn about your health insurance coverage and contact HMSA if you have questions about your benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for you.

We look forward to working with you as your primary care provider in your patient-centered medical home.

____

Provider Name/Signature   Date

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Patient Name/Signature Date

Medical Records Policy

- We are happy to provide you a copy of your medical records gratis. Additional copies will require a charge.
- Please allow up to 3 weeks for medical record requests. Medical records for visits prior to October 2012 may take additional time.
- All record requests must be accompanied by a Release of Protected Health Information, available from our office.

Prescription Refill Policy

- Prescription refill requests must be made at the time of your appointment.
- Please allow 3-5 business days for all refill requests done outside of an office visit. Please note that for patient safety, you may be asked to come in for an appointment to receive a medication refill.
- Refills will not be done outside of office hours. Please do not call the after-hours answering service for such requests.

Changes in Demographic/Insurance Information

- It is your responsibility to advice the office of any changes in **insurance coverage**, or changes in **name, address, or telephone number.**

Payment Policy

- You will be required to provide proof of insurance at every visit. It is your responsibility to provide proof in the form of an insurance card or other documentation of valid insurance. In compliance with federal law, we will ask you for valid photo identification and keep a photocopy for our records.
- Your plan may have limitations on the frequency of services performed or where services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any providers office, any charges you incur, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf. If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to pay for services in full at time of visit.
- All co-payments will be collected at time of service. Co-payment amounts are estimated, and any balance will be adjusted by your insurance company.

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Insurance Authorization

Assignment of Insurance Benefits: I hereby authorize payment of medical benefits directly to the office of Dr. Stuart Lerner. I further authorize the release of any medical information necessary for processing the insurance claim and any referral necessary fo the care of the patient. I permit a copy of this authorization to be as valid as the original. I understand that all costs not paid by the insurance become my responsibility unless otherwise prohibited by state or federal regulations. I understand that if I do no inform the office of Dr. Stuart Lerner of changes in my insurance coverage within 30 days from the date of service that I may be responsible for any charges incurred due to a delay in timely submission of charges.

Acknowledgement of Receipt of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up care among multiple health care providers.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations.

I have been informed by you of your privacy practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such notice prior to signing this consent, and acknowledge that I have studied the privacy practices. I understand that I may contact this office any time to request a copy of the Notice of Private Practices.

I understand the above office policies, and acknowledge the above information to be true to the best of my knowledge.

____

Patient/Patient Representative Name (Print)

____

Patient/Patient Representative Signature

____

Date