APPOINTMENT DATE AND TIME_____

15520 19 Mile Road * Suite 480
Clinton Twp., MI 48038
P: 586-228-1010 F: 586-228-8570
Seville Plaza - second building on the left

Internal Medicine
Anu Duvoor, M.D.
Harjeet Jhajj, D.O.
Linda Kosal, D.O.
Nina Rehman, D. O
Sanjay Vora, D.O.

Nephrology
Shadi Bashour, D.O.
Joseph Kaiser, D.O.
Tara Nelson, D.O.

WELCOME TO OUR OFFICE!

We're here to listen… to educate… to help you understand your illness, your options, and what to expect for the future. We help our patients live in knowledge, not fear.

We empower our patients. Making sure you have the knowledge to make informed decisions and manage your symptoms.

As specialists in Internal Medicine and Nephrology (kidney-related health problems). We have training in prevention, diagnosing, and treating adult medical disorders, from the simplest to the most complex. This includes a broad spectrum of disorders including the heart and circulation, digestive, respiratory, arthritis, diabetes, cancer, kidney, neurologic, skin, and hormonal.

Our caring staff strives to provide medical care, treatment, education, and health solutions through a team alliance between patient, physician, office staff, health plans, and specialty services.

In addition to the physicians in the practice, we have a highly trained staff including professional administrator, medical billers, certified medical assistants, and various skilled clerical personnel.

OFFICE HOURS

MON: 8am – 5pm	TUE: 8am – 5pm	WED: 8am – 5pm
THU: 8am – 5pm	FRI: 8am – 12pm	M-TH PHONES ARE ON UNTIL 4PM

To ensure that your first visit to our office is as convenient and efficient as possible, please **arrive 15 minutes early**, complete these forms and **bring with you to your appointment**. Always bring your insurance card and photo identification with you to every appointment, along with a **current medication list**. Your copay (if one applies) is due at the time of service.

Kidney patients: **Please come prepared to leave a urine sample or bring one with you**

This office schedules patients by appointments only. We will accommodate your schedule to the best of our ability, however, emergency situations may alter scheduled times. If you are ill, call as early in the day as

possible so that we can accommodate you promptly. **Avoid calling Monday mornings (during busy phone times) with non-emergent issues.**

DIRECTIONS

From the East: take I-94 WEST to Hall Road (M-59) WEST. Take Hall Road to Garfield SOUTH. Take Garfield to 19 Mile Road WEST. Our office is on the SOUTH side of 19 Mile Road, in the **Seville Complex**. We are 1/4-mile EAST of Hayes.

From the West: take I-94 EAST to Hall Road (M-59) WEST. Take Hall Road to Garfield SOUTH. Take Garfield to 19 Mile Road WEST. Our office is on the SOUTH side of 19 Mile Road, in the **Seville Complex**. We are 1/4-mile EAST of Hayes.

Seville Plaza
second building on the left

PATIENT INFORMATION * *PLEASE PRINT*

NAME_____**Birthdate**_____
Last First MI

Gender Identity: M - ☐ F - ☐ F-M - ☐ M-F - ☐ Marital Status: S ☐ M ☐ W ☐ D ☐

Sexual Orientation: Heterosexual - ☐ Homosexual - ☐ Bisexual - ☐ No Disclosure - ☐

Home Phone #_____ **Cell Phone #** _____

Address: _____**City:** _____**State**_____**Zip**_____

SS#_____**Employer:**_____ **Work Phone:( )**_____

SpouseName:_____**Employer:**_____**Work Phone:( )**_____

Spouse SS#_____ **Family Dr. Name:**_____

Family Dr. Address:_____

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____

Name of Insured:_____**Birthdate:**_____**SS#**_____

Relationship to patient: Self ☐ Spouse ☐ Other ☐

Insured's Employer:_____

SECONDARY INSURANCE

Insurance Company Name:_____

Name of Insured:_____**Birthdate:**_____**SS#**_____

Relationship to patient: Self ☐ Spouse ☐ Other ☐

Insured's Employer:_____

Please list someone we can contact in case of an emergency:

Name_____**Phone # ( )**_____**Relationship**_____

Who referred you to our office?_____

_____**Date**_____
Signature of patient/legal guardian

******* THIS FORM IS UPDATED YEARLY ******

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Macomb Internal Medical Associates, P.C. to release my private medical information to the following person(s), if they are involved in the status of my healthcare or payment of health care, provided that the information is relevant to the person's involvement with the patient:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Health information may include, but not limited to, test results, medication changes and appointment scheduling. If you identify certain specific results or information that you do not want other people to have access to, then we will abide by your request. In the event of emergencies, I understand that my medical information might be shared on a need to know basis, at the discretion of my physician. Upon my death, appropriate legal documentation will be required for release of my medical records to anyone requesting them.

➔_____Date_____
Signature

Macomb Internal Medicine Associates, P.C.
15520 19 Mile Road, Suite 480
Clinton Township, Michigan 48038-6332

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and healthinsurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR)and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies thatpatients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect andgiving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Macomb Internal Medicine
Associates Financial Policy

Thank you for choosing us for your care. We are committed to providing quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; we have developed this financial policy. We are entering into an agreement with you, with obligations on both sides. Please read it, ask us any questions you may have, and sign in the space provided.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service; I agree to pay for all costs and expenses, including reasonable attorney fees.

General Information:

- In order for you to be a patient with Macomb Internal Medicine Associates, you will be required to fill out a Patient Information Form, and sign and abide by this Financial Policy. We will also take a copy of your driver's license and current insurance card(s).
- Our fees are representative of the usual and customary charges for our area.
- If you believe your services are covered by another party and supply all required billing information, we will send the claim in for you as a courtesy, however, you remain responsible for payment.

Insurance

- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Billing your insurance is a courtesy service we provide for you. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility.
- Your insurance coverage is a contract between you and the insurance company. It is your responsibility to know your insurance benefits.
- We participate in many health insurance plans. If we participate in your health insurance plan, our fees are subject to a contracted fee schedule. It is your responsibility to verify participation prior to service. Participation may change at any time.
- If your insurance company has not paid within 60 days of service, the payment will become your responsibility. It is your responsibility to contact your insurance company regarding a disputed insurance claim.
- We will not bill a 3rd party.
- It is your responsibility to notify us of any changes in insurance coverage.

Patient Responsibility for Payment:

- Co-payments, co-insurance and charges that apply to your deductible are due at time of service. Insurance companies require that we collect your co-pay at time of service.
- If you are unable to pay and have a good credit history with our office, we may allow you to pay for services on a financial agreement. Reasonable and timely monthly payments are expected. Missing a payment means that you have broken the contract with us and may result in a referral to a collection agency and dismissal from the practice. We allow one financial agreement at a time per family. The original agreement must be paid in fill before another agreement may begin. Additional services will not be added to an existing financial agreement. New patient charges may not be paid on a financial agreement.
- If you are on a payment plan or have had payment issues in the past, we will place your account on "Cash Pay" terms. This means we will require payment of deposit before you are seen by a Provider.
- We accept payment by cash, check, VISA, Mastercard, and Discover

Billing:

- You will receive a monthly statement listing all services, payments and adjustments, and noting the date your insurance was billed. The statement will specify an amount due from you, and payment is due upon receipt.

Non-Payment:

- If you do not pay the patient due portion of your bill, our collection analyst will send you a letter stating you must pay within specified period of time. You must contact the billing office to discuss payment arrangements. Please be aware that failure to pay will result in a referral to a collection agency, which may affect your credit rating.
- If we refer your account to a collection agency, you will be charged for all costs and expenses and any reasonable attorney fees.
- Referral to a collection agency may result in dismissal from our practice or refusal of care.
- There is a $40 fee for all NSF checks. After 2 NSF checks, we will no longer accept checks as a form of payment.

Services from other Providers:

You may have additional medical services ordered by your Provider, such as laboratory or pathology tests, x-rays or other radiology tests. Our clinic may draw blood, or take a sample, and send it to another company. You will receive a separate bill from that office for their services.
You must make your own arrangements for payment with companies outside our office.

_____ **DATE**_____

Patient/Patients Representative Signature

PATIENT HISTORY FORM
** PLEASE PRINT CLEARLY **

DATE_____

PATIENT NAME_____
DATE OF BIRTH_____

Allergies to Medications, X-ray Dyes, or Other Substances ❑ YES* ❑ NO
*** If YES, please list name/substance and type of reaction**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

DRUG NAME	DOSE	DIRECTIONS	DRUG NAME	DOSE	DIRECTIONS

Do you take any of the following:								
Aspirin	YES	NO	Tylenol	YES	NO	Motrin	YES	NO
Advil	YES	NO	Ibuprofen	YES	NO	Aleve	YES	NO

Primary Pharmacy Name:_____ Location:_____ Phone:_____

Secondary Pharmacy Name:_____ Location:_____ Phone:_____

PREVENTIVE HEALTHCARE

Indicate the last time the following were performed (or "never")

Tetanus:_____ **Pneumovax(pneumonia)_____**
Zostavax(shingles)_____ **Flu:_____**
Covid _____

Colonoscopy:_____ **Bone Density:_____**
Mammogram:_____ **Prostate Exam:_____**

PATIENT NAME:_____

FAMILY HISTORY

RELATION	AGE	HEALTH PROBLEMS	LIVING STATUS
Father **Name:**		Hypertension Heart Disease Diabetes Stroke Thyroid Disease Kidney Disease Depression Cancer Type:_____ Other_____	Alive Passed away
Mother **Name:**		Hypertension Heart Disease Diabetes Stroke Thyroid Disease Kidney Disease Depression Cancer Type: _____ Other_____	Alive Passed away
Sibling **Name:**		Hypertension Heart Disease Diabetes Stroke Thyroid Disease Kidney Disease Depression Cancer Type:_____ Other_____	Alive Passed away
Sibling **Name:**		Hypertension Heart Disease Diabetes Stroke Thyroid Disease Kidney Disease Depression Cancer Type:_____ Other_____	Alive Passed away
Sibling **Name:**		Hypertension Heart Disease Diabetes Stroke Thyroid Disease Kidney Disease Depression Cancer Type:_____ Other_____	Alive Passed away

SOCIAL HISTORY

Place of Birth: _____
Employment Status: Full-time Part- time Retired Student
Where Employed:_____
Who lives at home with you:_____
Do you live in a health care facility? YES NO
Name of Facility: _____
How many children do you have? _____

LIST OF DOCTORS

Please list the names of all the doctors who are currently treating you

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PATIENT NAME:_____

Exercise	❑ Sedentary (No exercise) ❑ Mild exercise (climb stairs, walk) ❑ Occasional vigorous exercise (work or recreation, less than 4x/week for 30 minutes) ❑ Regular virorous exercise (work or recreation, 4x/week for 30 minutes)		
Diet	Are you dieting? YES NO If yes, are you on a physician prescribed medial diet? YES NO # of meals you eat in a average day? _____ Do you restrict salt? YES NO		
Caffeine	None Coffee? how many cups?_____/day Tea? how many cups?_____/day Cola? cans per day?_____		
Alcohol	Do you drink alcohol? YES NO TYPE: BEER WINE LIQUOR MIXED DRINKS How much? _____		
Tobacco	Do you currently use tobacco and/or have you used tobacco? CIGARS CIGARETTES CHEWING TOBACCO _____ Packs per day? _____ # of years you smoked _____ If you quit, what year:_____		
Drugs	Do you currently use recreational or street drugs?	YES	NO
	Have you ever given yourself street drugs with a needle	YES	NO
Personal Safety	Do you live alone?	YES	NO
	Do you have frequent falls?	YES	NO
	Do you use a seatbelt?	YES	NO
SUNSCREEN	Do you use sunscreen? **EVERYDAY SOME VACATION ONLY**	YES	NO
Occupational Exposure	**Please Circle Exposure:** Lead Asbestos Chemicals Radiation Second hand smoke Pesticides Blood borne pathogens	YES	NO
Hobbies/Interests			

PAST MEDICAL HISTORY

**** Please check all that apply to <u>you</u> ****

_____ High blood pressure	_____ Heart attack	_____Heart disease
_____ Stroke	_____ Asthma	_____ Emphysema
_____ Pneumonia	_____ Allergies	_____Gallstones
_____ Hepatitis	_____Ulcers	_____ Diverticulitis
_____ Urinary infections	_____Kidney stones	_____Kidney disease
_____Prostate problems	_____Diabetes	_____High cholesterol
_____Thyroid disease	_____Cancer type_____	_____Anemia
_____Migraine	_____Depression	_____Anxiety
_____Arthritis	_____Headache	_____Gout

Other, please describe:_____

PATIENT NAME:_____

PAST SURGICAL HISTORY

TYPE OF SURGERY	YEAR

REVIEW OF SYSTEMS *** Circle any symptoms you have***

General
Fever
Chills
Weight Loss
Weight Gain
Night Sweats
Fatigue
Weakness

Skin
Rash/purple or red
Spots/pigment change
Hair Loss
Sun sensitivity
Hives
Thickening or tightening of skin
Calcium deposits
Fingers/toes turn colors the cold
Nodules
Psoriasis
Nail problems
Dry skin

Mouth
Sores in mouth
Dry mouth
Dental problems
Loss of taste
Difficulty swallowing
Bleeding gums
Sore throat
Hoarseness/change in voice

GI/Abdomen
Abdominal pain
Heartburn
Nausea
Vomiting
Difficulty swallowing
Diarrhea
Constipation
Blood in stools
Black, sticky stools
Mucous in stools
Jaundice

Women Only
Vaginal discharge
Vaginal ulcers
History of miscarriage
High blood pressure during pregnancy

Endocrine
Cold Intolerance
Heat Intolerance
Excessive thirst
Excessive urination
Excessive sweating
Flushing

Neurologic
Migraines
Headaches
Numbness/tingling
Muscle weakness
Incontinence
Seizures
Muscle cramps
Difficulty thinking or remembering

Nose
Runny nose
Nasal congestion
Nose bleeds
Deformity of nose
Swelling of nose
Red nose
Dry nose
Nose sores
Loss of sense of smell
Sinusitis

Heart
Chest pain
Stabbing chest pain/pericarditis
Irregular or rapid heart rate
Lightheadedness/passing out
Sleep on more than 2 pillows due to shortness of breath

Blood/Lymph
Swollen lymph nodes
Blood clots
Bleeding tendency
Bruising
Transfusions

Men Only
Penile discharge
Penile ulcers
Prostate issues

Ears
Hearing loss
Earache
Ear pain
Swollen ear
Red ear
Floppy ear
Ringing in ears
Drainage from ear(s)
Vertigo

Scalp/Head
Hair loss
Scalp tenderness
Headache
Jaw pain with chewing

Eyes
Vision problems
Double vision
Red eye or pink eye
Eye pain
Dry eyes
Sandy, gritty sensation in eye(s)

Allergy
Frequent sneezing
Seasonal allergies
Increased infections

Lungs
Shortness of breath
Cough
Coughing up blood
Wheezing
Chest pain with breathing/pleurisy

Genitourinary/Urology
Pain/burning with urination
Difficulty urinating
Urinary incontinence
Cloudy urine
Blood in urine
History of STDs

Psychology
Depression
Anxiety/Panic Attacks
Insomnia or Disturbed sleep
Wake up unrefreshed
High stress level

MACOMB INTERNAL
MEDICINE ASSOCIATES, P.C.

MACOMB NEPHROLOGY ASSOCIATES, P.L.C.
15520 19 Mile Road, Suite 480
Clinton Township, Michigan 48038
586-228-1010

NOTICE OF PRIVACY PRACTICES

This Notice describes your rights regarding your health information and how it can be used and/or disclosed and how you can be given access to the information. The privacy of your healthcare information is important to us. Please review it carefully.

OUR COMMITMENT TO YOU!

We understand that medical information about you and your health is personal and confidential. We have always used, stored, and shared your information responsibly, and will continue to do so. This notice is in response to a new federal law regarding patient information and applies to all your records generated or received by our practice. This notice will tell you about the ways we may use and disclose information about you. Our entire staff is committed to following the standards, required by law, to protect your privacy.

We are required by law:

- To make sure that medical information that identifies you is kept private by following current privacy standards
- To inform you through this notice of our legal duties and privacy practices with respect to your information.

It is the right of this office to change this policy at any time as long as the changes are in accordance with applicable laws. Significant changes will result in the replacement of this Notice and the new Notice will be available upon request.

Healthcare Information Uses and Disclosures

Your healthcare information is used and disclosed for treatment, payment and healthcare operations; for example:

Treatment: Our office may use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you.

Payment: Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

Healthcare Operations: Our office will use and disclose your healthcare information in association with our healthcare operations. These operations include, but are not limited to: quality reviews, improvement and training activities, licensing and credentialing activities, certification and accreditation programs, and appointment reminders, by mail or phone.

Family and Friends: Your healthcare information may be released to a friend/family member or another person if that person(s) is involved in your care and disclosure is relevant to their involvement. You have the option to object to this disclosure . We will only disclose the information necessary to help with your treatment or payment of your healthcare.

Persons Involved in Your Care: Our office may use or disclose your private health information if it is necessary to notify or aid in the notification of a family member, personal representative or another person responsible for your care of your location, your general condition or death. If you are present and capable of deciding what information and to whom that information should be released, you will be given that option. If you are incapacitated because of an emergency, we will use or disclose only that private health information that is deemed necessary in our professional judgment and experience to make reasonable recommendations of your best interest in allowing another individual to pick up prescriptions, medical supplies, x-rays or other similar forms of healthcare information.

Marketing Health-Related Services: We will not use your private healthcare information for marketing programs without your written authorization.

Required by Law: If you are involved in a lawsuit or dispute, we may disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process.

Public Health: We may disclose medical information about you for public health activities. These activities generally include the following, but is not limited to:

- to prevent/control disease, injury or disability
- to report abuse, neglect or exploitation
- product recalls

National Security: We may disclose to military officials the health information of Armed Forces personnel under certain circumstances. We may disclose this information to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances as dictated by federal regulation.

Coroners, Medical Examiners and Funeral Directors: The release of medical information may be necessary , for example, to identify a deceased person, determine cause of death, or assist funeral directors in carrying our their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Access: You have the right to look at or obtain copies of your personal health information, with limited exceptions. To obtain access to your healthcare information, you must submit the request in writing to our office. Contact information is provided at the bottom of this Notice. If you request to review your private medical information with a staff member present, we may assess a reasonable, cost-based fee for the time spent reviewing your medical information. If you request a copy of the information, we may asses a reasonable cost-based fee for the costs of copying, mailing or obtainment of other documents associated with your request.

Disclosure Accounting: You have the right to receive a list of requests that have been made for disclosure of your personal health information from our office for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period we may charge you a reasonable fee for this request.

Restriction: You have the right that we place restrictions on our use or the disclosure of your personal healthcare information. **We are not required to abide by these restrictions,** but if we do, we will accept your request (except in emergency situations). To request restrictions, you must make your request in writing to the office manager. If you provide us permission to use or disclose your medical information, you may revoke that permission, in writing, at any time.

Alternative Communication: You have the right to request that we communicate with you about your health information by other forms of communications or to other locations. These requests must be made in writing. Your request must specify the form of communication, or the alternate location, and provide satisfactory explanation how payments will be handled under these alternate circumstances. We will accommodate all reasonable requests.

Amendment: You have the right to request that we amend your healthcare information. Again, your request must be made in writing and it must explain why the information should be amended. We have the right to deny this request under certain circumstances as dictated by the federal regulations regarding HIPAA.

Questions and Complaints

If you need or want more information regarding our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision our office has made regarding access to your healthcare information or a response we made to your request to amend or restrict the use and/or disclosure of your healthcare information or to have us communicate with you using an alternative means or location, you have the right to complain to us using the contact information listed on the bottom of this Notice. You may also contact the Department of Health and Human Services in writing. Our office supports your right to privacy of your healthcare information. We will not retaliate in any way if you deem it necessary to file a complaint.

Contact Information

Contact Officer: Office Manager
Telephone: 586-228-1010 Fax: 586-228-8570
Address: Macomb Internal Medicine Associates or Macomb Nephrology Associates
15520 19 Mile Road, Suite 480
Clinton Twp., MI 48038

3/14/2003

PRIVACY NOTICE
Acknowledgement of Receipt

Patient Name: X_____

We are required to provide you with a copy of our Notice of Privacy Practices, upon request, which states how we may use and/or disclose your health information.

I acknowledge that I may request a copy of the Privacy Notice from Macomb Internal Medicine Associates, P.C.

X_____
Patient Signature **Date**

_____
Personal Representative Signature **Relationship to Patient** **Date**

FOR OFFICE USE ONLY

- ☐ **Patient refused to sign**
- ☐ **Patient unable to sign due to communication/language barrier**
- ☐ **Patient unable to sign due to emergency situation**
- ☐ **Other (please explain)**

_____

_____

_____

_____
Office Representative Signature **Date**

Macomb Internal Medicine Associates, P.C.

15520 19 Mile Road, Suite 480
Clinton Twp., MI 48038-6332

Patient-Provider Agreement

Our office is participating in a new model of healthcare focused on you, the patient.

Patient-Centered is a way of saying that you, the patient, are the most important person in the health care system. You are the center of your healthcare.

You are joining a team that provides comprehensive, coordinated primary care and cultivates partnerships between patients, their physicians, and their family.

I am interested in providing you the best care I can and would like you to understand that it is important to me that you use this office as your medical home. That means, making regular appointments, participating in action plans and making sure that I have all medical information to provide you the best care.

This information is outlined in our brochure. I would like you to sign this agreement with me to acknowledge that you received our brochure and agree to your roles and responsibilities.

I have received the brochure(upon request) describing this model of care, what I can expect from my physician and what is expected of me.

_____	_____
Patient Name ** PRINT **	**Birth Date**
_____	_____
Patient SIGNATURE	**Date**
_____	_____
Physician SIGNATURE	**Date**

Macomb Internal Medicine Associates

Patient Web Portal
Informed Consent Form

The purpose of a patient web portal is to allow communication through the internet between our clinical staff and you, the patient in a secure, safe manner. The web portal is encrypted, secure, and HIPAA compliant. Our office will send you an unsecure email to the address you have provided to us, alerting you that you have a secure email message awaiting at the web portal. You will need to sign into your account using your username and password.

As with any medical information, the communication is private and protected and will become part of your permanent medical record. Please make sure you keep your user ID and password secure so that no one has access to your information. Secure emails and information can only be read by someone who knows the right password to log into the web portal (similar to online banking). If you think someone has obtained your password, you can go to the web portal and change your password.

You agree not to hold our clinic or any of its staff liable for any problems that may arise that are out of our control. You also understand and comply with our clinic's policy and procedures, specifically those given to you today regarding using the web portal and by signing, agree to comply.

The web address for the portal is: https://macombintmed.myezyaccess.com

My email address (please print): _____

Patient Name (please print): _____

Patient Date of Birth: _____

Today's Date: _____

Patient Signature: _____