Dr. Tiffany Lee
4150 Snapfinger Woods Dr. Ste 100
Decatur, Ga 30035
Phone: 404-286-7874
Fax: 404-286-7858
Email: tleemd@strawbridgehealth.com

`Welcome to Strawbridge Health, LLC

We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner. Below is a brief description of our office's policies. These policies are put in place to ensure a smooth experience for all patients. Please read this letter in its entirety and be sure to sign stating that you understand the policies. Please be advised that the list below is a succinct version of the Strawbridge Health, LLC regulations. If you have questions about anything else be sure to let us know.

1) **Appointment guidelines:**
    a. The following is a list of emergency conditions. If you are having **ANY** of the following symptoms you will be directed to the nearest **emergency room**:

- ✓ Chest pain/chest pressure
- ✓ Shortness of breath/difficulty breathing
- ✓ Severe/persistent diarrhea or vomiting
- ✓ Coughing/vomiting blood
- ✓ Uncontrolled bleeding
- ✓ Changes in mental status such as severe confusion
- ✓ Sudden weakness

    b. The following is a list of conditions that will warrant a sick visit with our office. If you are experiencing any of these symptoms we will schedule you the same day **or** within 24 hours:

- ✓ Flu like symptoms
- ✓ Sore thoat
- ✓ Urinary tract infection
- ✓ Ear ache
- ✓ Yeast infection

    c. Our office observes a 15-minute grace period for all patients. If you will arrive any later than 15 minutes after your appointment time you may be asked to reschedule for another day.
    d. If you have been seated in the lobby for more than 30 minutes you are welcome to reschedule your appointment with our staff.
    e. Chronic care visits and non-emergent visits may be scheduled during clinic hours at which time review of medications, treatment plans by the Primary Care Physician and/or other providers such as specialists and ancillary services will be reviewed and discussed.
2) **Missed appointment guidelines:**
    a. Patients with a no call, no show appointments will be assessed a $35.00 fee to be paid upon the next scheduled appointment.
3) **Contacting your provider:**
    a. Business hours are 9:00 am – 5:00 pm. During those times patients are not allowed to speak to the provider. You are welcome to leave a message for the provider that will be relayed at the end of the day. If your matter is urgent, you may ask the medical assistant to give the message to the provider immediately. Please allow 24-48 hours for the staff to return **non-emergency** phone calls.
4) **Balances:**
    a. Additional payments for services are expected at the time of service
    b. If you have an outstanding balance you may not receive services until the account is current.

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5) **Medications:**
   a. Strawbridge Health, LLC does not prescribe chronic pain medications e.g. Oxycodone, Percocet, Hydrocodone
   b. If you are prescribed a **new** medication for a chronic condition like high blood pressure, high cholesterol, asthma, diabetes, etc. you will only be given a 30-day supply after which time it is your responsibility to schedule an appointment so that medication effectiveness and possible side effects may be assessed. Then a 90 day supply or a dosage adjustment will be done.
   c. **All** persons with chronic conditions like high blood pressure, high cholesterol, asthma, diabetes, etc. are required to schedule 3- month follow up appointments to continue your medication; unless otherwise discussed with the provider.
6) **Paperwork that requires the physician's signature:**
   a. If you need medical records or any other documentation from our office, please be aware that it will take 72 business hours to process the request. The term "documentation" means, but is not limited to:
      i. Vaccination records
      ii. FMLA paperwork
      iii. Work physicals
7) **Lab/imaging results:**
   a. STD/HIV results will not be discussed over the phone by the medical assistant. **All** STD panels require a follow up with the physician regardless of the results.
   b. Imaging results cannot be discussed over the phone by the medical assistant. If you do not have a follow up appointment scheduled, you may schedule one or ask that Dr. Lee give you a call back regarding the results.
8) **Patient Rights and Responsibilities (a full list is available in the lobby):**

You have the right to:
- ✓ Fair treatment
- ✓ Access your medical records
- ✓ Timely health care
- ✓ Refuse treatment
- ✓ File a complaint

You have the responsibility of:
- ✓ Informing staff of billing info change
- ✓ Providing accurate health information
- ✓ Adhering to the 15-minute grace period
- ✓ Keeping all scheduled appointments

Please sign below stating that you have read and understood the welcome letter **and** that you have received a copy of the patient rights/responsibilities.

_____	_____	_____
Patient Name	Patient Signature	Today's Date

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. There is a full version of what HIPAA means for you as a patient located at: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html. There are rules and restrictions on who may see or be notified of you Protected Health Information (PHI). The restrictions do not include the normal exchange of information within our office. HIPAA provides certain right and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information regarding your rights to privacy is available from the website listed above. Patient information will be kept confidential except when it is necessary to provide services or to ensure administrative matters related to your care are handled properly. This may include, but not limited to: the sharing of information with other healthcare provider, laboratories and health insurance companies. Patient information (treatment plans, insurance forms, EOBs, etc.) may be stored in file cabinets that are not accessible by another patient. Records may be left, at least temporarily, in the administrative area such as the front office, provider's desk, examination rooms, etc. Those records will not be available to anyone other than the office staff. You agree to normal procedures utilized within the office for handling of you PHI and other documents or information. Your confidential information will never be used for the purposes of marketing or advertising products, goods or services without your permission.

Please initial the following statements, stating that you agree to having your SHI used in such ways

_____ You agree to us sending electronic referrals to specialists, including SHI and x rays if needed

_____ You give us permission to remind you to take pre-medications prior to appointments if needed

_____ You agree to vendors having access to your SHI as long as they abide by HIPAA laws

_____ You understand and agree to inspection of the office and review of documents which may include SHI but government agencies or insurance payers in normal performance of their duties

_____ You agree to bring any concerns or complaints regarding your privacy to the attention of the provider or the office manager

_____ You understand that you have the right to file a complaint if you feel like your SHI is being used inappropriately

_____ You give us permission to call in or fax prescriptions that are needed and share your SHI with the pharmacy if needed

By signing below, you agree that you have read the HIPAA terms for Strawbridge Health, LLC. You also understand and acknowledge the agreement to the terms set forth in the HIPAA policy and consent to any future updates.

_____ Patient Signature

_____ Today's Date

Patient Name: _____ Patient DOB: _____

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PATIENT INFORMATION			
Parent/Guardian Name (if under 18):			
Patient Name:	Patient DOB:		
Telephone Number:	☐ Cell	☐ Home	☐ Work
Street Address:			
City, State, Zip Code:			
Email Address:			

Marital Status:	Race:	Ethnicity:	Preferred Contact:
☐ Divorced	☐ Asian	☐ Cambodian	☐ Cell phone
☐ Life partner	☐ Black	☐ Filipino	☐ Email
☐ Married	☐ White	☐ Hispanic/Latino	☐ Home phone
☐ Single	☐ Other	☐ Non- Hispanic	☐ Patient portal
☐ Widowed	☐ Prefer not to answer		☐ Work phone

EMERGENCY CONTACT INFORMATION	
Contact Name:	Contact Number:
Contact Relationship:	Alternate Contact Number:

PREFERRED PHARMACY
Pharmacy Name:
Street and City:

INSURANCE INFORMATION

Name of Insurance Company: _____

Member ID Number: _____

Group Number: _____

Effective Date: _____

Claims phone number: _____

AUTHORIZATION FOR TREATMENT

I do consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Strawbridge Health, LLC to me or to the above-named minor of who I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid contract. I furthermore agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Strawbridge Health, LLC to release information requested by insurance company and/or its representative (if applicable). I fully understand this agreement and consent will continue until cancelled by me in writing.

_____	_____	_____
Patient/Parent Name	Patient/Parent Signature	Today's Date