INDUSMEDICAL ASSOCIATES

Patient Partnership Plan

Dear Patient, _____ Date of Birth____/____/_____

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "Partnership" between you and your doctor. As our "partner in health" we ask to help us in the following ways:

Schedule visits with Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow- up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know my condition progresses after I leave the office. Returning to my doctor on time gives him or her, the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointment as soon as possible.

Appointments that are not cancelled with 24 hours in advance will result in a $25.00 fee.

Call the Office When I Do Not Hear Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, ***at any time***, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Date Provider Signature

760.202.0686
www.indusmedicalassociates.com
35400 Bob Hope Drive, Suite 209
Rancho Mirage, CA, 92270

INDUS MEDICAL ASSOCIATES

RECORDS RELEASE AUTHORITY

I, _____ hereby request that _____ **release** my health information as described below.

1. This authorization is limited to the following type of information:
   - ○ All medical information
   - ○ Immunization Record
   - ○ Medication List
   - ○ X-ray and Imaging reports
   - ○ Lab results
   - ○ All medical records relating to _____
   - ○ Other _____
2. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral or mental services.
3. THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

   INDUS MEDICAL ASSOCIATES

   35-400b Hope Dr. Ste 210, Rancho Mirage CA, 92270 Tel (760) 202-0686 Fax (760) 770-4563
4. The recipient may use the medical records and type of information authorized only for the following purposes:

   ○ Patient access ○ Continuation of care ○ Application for insurance ○ Other _____
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise, revoked, this authorization will expire on the following date, event, or condition in one year.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Director of Health Information Services.

NOTE: If our Physician feels the need to view records from your previous physician or specialist, we will fax this form with your signature of authorization to their office so they may release your records to us.

7. Please sign below:

_____ _____
Signature of Patient or legal Representative Date

_____ _____
Relationship to Patient Signature of Witness

Recipients of outpatient psychotherapy records are required to destroy these records within 60 days unless they are incorporated into the patient's medical records. It is the responsibility of the recipient to follow confidentiality policies and procedures for the maintenance and destruction of protected health information.

INDUS MEDICAL ASSOCIATES, INC.
35-400 BOB HOPE DR STE.210
RANCHO MIRAGE, CA 92270
PHONE: (760)202-0686
FAX: (760)770-4563

PATIENT: _____
SSN# _____
D.O.B: _____
PCP: _____