ADVANCED INTERNAL MEDICINE INC.

PATIENT INFORMATION :

LAST NAME | FIRST NAME | MI

DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER | E-MAIL ADDRESS

ADDRESS

CITY | STATE | ZIP CODE

CELL PHONE | HOME NUMBER | WORK NUMBER

EMERGENCY CONTACT | RELATIONSHIP TO PATIENT | PHONE NUMBER

GENDER : ☐MALE ☐FEMALE

MARITAL STATUS : ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOW

ETHNICITY : ☐HISPANIC ☐NON-HISPANIC

PREFERRED LANGUAGE : ☐ENGLISH ☐URDU ☐SPANISH ☐FARCI

RACE : ☐AFRICAN/AFRICAN AMERICAN
☐ASIAN/ASIAN AMERICAN
☐CAUCASIAN/EUROPEAN AMERICAN
☐PACIFIC ISLANDER / HAWAII
☐NATIVE AMERICAN / ALASKAN
☐OTHER RACE

CONSENT OF RELEASE OF INFORMATION AND PHYSICIAN REIMBURSEMENT

I certify to the accuracy of the patient and insurance information provided to the physician and authorize the release of any medical information necessary to process this claim. I authorize my insurance company to remit payments directly to the physician.

_____ **Date :** / /

Patient or Responsible Party Signature

FINANCIAL AGREEMENT

I understand that payment for any service not covered or denied by my insurance company (co-payment/insurance, deductible, pre-existing condition, failure to obtain a prior authorization/referral, etc.) will be my responsibility. I also understand that my insurance plan may not cover certain preventive charges as spirometry, urinalysis, pulse O2 and stool hemocult testing and therefore authorize my physician to bill these charges to me instead of my insurance company.

**** Patients who have HMO Policies such as Optimum Choice, MDIPA, Aetna HMO, Cigna HMO, Trigon Healthkeepers, Medicaid Medallion, Amerigroup and Unicare are required to select a Primary Care Provider (PCP) before being treated.** I understand that if I have an HMO policy and have not selected the rendering physicians my primary care, I am waiving my insurance benefits and will be responsible for payment.

_____ **Date :** / /

Patient or Responsible Party Signature

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Please state your relationship to the policy holder: _____

Policy Holder's Name:_____ Social Security #:_____

Date of Birth:____/____/_____

Name of Insurance Co.:_____ Phone: (_____) _____ - _____

Policy #:_____ Group #:_____ Co-pay amount: $_____

Claims Mailing Address: _____

SECONDARY INSURANCE INFORMATION

Please state your relationship to the policy holder: _____

Policy Holder's Name:_____ Social Security #:_____

Date of Birth:____/____/_____

Name of Insurance Co.:_____ Phone: (_____) _____ - _____

Policy #:_____ Group #:_____ Co-pay amount: $_____

Claims Mailing Address: _____

WORKMANS COMPENSATION INFORMATION

Claim #:_____ Date of Accident:____/____/_____

Employer:_____ Work Phone:(_____) _____ - _____

Employer's Address:_____

Name of Person to Contact/Claims Adjuster:_____

Phone: (_____) _____ - _____

NOTICE OF CANCELLATION POLICIES

Effective as of January 2nd, 2008 Advanced Internal Medicine implemented a new cancellation policy. Please review the policies outlined below.

OFFICE VISIT : 24 hour notice is required to cancel an office appointment. A fee of $25.00 will be charged for all no show appointments and cancellations with less than 24 hour notice.

PHYSICAL / MEDICAL CLEARANCE : 48 hours notice is required to cancel a physical / medical clearance appointment. A fee of $50.00 will be charged for all no show appointments and cancellations with less than 48 hour notice.

I agree that I have been notified, in writing, of the policy changes with regard to appointments for Advanced Internal Medicine. I understand that if I fail to comply with these policies I may be subject to the charges outlined above. I further understand that missed appointment charges must be paid before subsequent appointments can be honored.

_____ _____

Patient or Responsible Party Date

PRIVACY NOTICE

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, **(The Health Insurance Portability and Accountability Act of 1996) (HIPAA),** mandates that we issue this new revised **Privacy Notice** to our patients. This notice to our patients meets all current requirements as it relates to **Standards for Privacy of Individually Identifiable Health Information IIHI**; affecting our patients. You are urged to read this:

As part of the privacy standard, implemented on April 14, 2001, you are required to provide our office with a new, signed and dated **Privacy Notice**.

Our privacy notice informs you of our use and disclosure of you **Protected Health Information (PHI),** defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual."

Our office will use or disclose your PHI for purposes of treatment, payment, and other healthcare purposes as required to provide you the best quality healthcare services that we offer. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access.

You, as our patient, may revoke any Consent at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process. To revoke the Consent you will have to provide this office with a written request with your signature and date and your specific instructions. Any revocation will not apply to information already used or disclosed.

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes. If the physician agrees with the request, we are bound by law to abide to any changes.

In limited circumstances, the Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities including: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health care needs; judicial and administrative proceedings; and activities related to national defense and security. There are specific state laws that require the disclosure of health care information related to Hepatitis C and AIDS.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclosure your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign the agreement as a condition of receiving care. It is the law that your rights are communicated in this manner. It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect our PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this privacy notice.

Thank you.

_____

Signature of Patient of personal representative

_____

Name printed

_____

Date

OFFICE POLICIES

Referrals
Referrals must be requested at least three working days before the date the referral is needed. Referrals will only be given if the doctor feels a specialist's attention is needed. You must see the doctor before he/she will refer you to a specialist unless the physician decides otherwise.

Prescription Refills
When you see the doctor a prescription will be written for enough of your routine medication to last until your next follow up. If you need an emergency refill, please call your pharmacy and request a refill from them. They will contact our office for permission. Please allow two working days for any refill. If you have not seen the doctor within a three-month period, you need to have a follow-up before any refills can be authorized.

Test Results
If your test results show something unusual, we will contact you to schedule an appointment to discuss the results. Should you like to discuss you test results, please schedule an appointment with the doctor. Abnormal test results will not be given over the phone. Please be aware that test results can take anywhere from two days to two weeks to reach our office.

Payments
Office payments and co-insurance payments are due at the time of service. There is a $25.00 fine for all returned checks. Please make every effort to pay your bill in a timely manner. Financial arrangements can be made for anyone facing a hardship.

Appointments
Please realize that if you miss an appointment someone sick might have been able to use it. We request that you notify our office if you are unable to keep your appointment.

Medical Records
We require seven days notice for all medical records. There is no charge for medical records sent to another physician. There is a charge of fifty cents per page for copying records for your personal use.

I have read and I understand all of the above office policies.

Signature:_____ **Date:**_____

HEALTH HISTORY

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

HEALTH HABITS

Do you now, or have you ever smoked?

☐ Yes ☐ No No. Years _____ Pack/day _____ Date Quit _____

Do you drink alcoholic beverages? ☐ Every day ☐ Most days ☐ Rarely

Illicit Drugs? ☐ Yes ☐ No

Blood transfusion ☐ Yes ☐ No

Do you exercise? ☐ Regularly ☐ Occasionally ☐ Rarely

Do you drive? ☐ Yes ☐ No Seatbelt? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

FAMILY RECORD

	Alive	Deceased	Age at Death	Cause of Death
Mother:				
Father:				
Other:				

FAMILY HISTORY

(Circle appropriate letter for Mother, Father, Brother, Sister, Children)

Arthritis	M	F	S	B	C	Thyroid dz.	M	F	S	B	C
Asthma	M	F	S	B	C	Kidney dz.	M	F	S	B	C
Angina	M	F	S	B	C	Heart dz.	M	F	S	B	C
Hypertension	M	F	S	B	C	Cancer	M	F	S	B	C
Stroke	M	F	S	B	C	Seizures	M	F	S	B	C
Diabetes	M	F	S	B	C	Hepatitis	M	F	S	B	C

Other Diseases or Illnesses in Family: _____

_____

Is your Spouse in Good Health? _____

_____