LEONID REMENSON, MD PA, General Psychiatry & Psychopharmacology
ANALOGY COUNSELING, Inc., Nanette Vitale, MSW, LCSW
Patricia (Tricia) Conlon, LMFT

PATIENT IDENTIFICATION (PLEASE PRINT): **Date**_____
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

NAME: LAST_____FIRST_____MIDDLE_____

STREET ADDRESS_____ APT._____

CITY_____STATE_____ZIP_____ EMAIL _____

HOME PHONE: WORK PHONE: MOBILE:

Which would you prefer as a reminder: automatic phone call ☐ text message ☐ both ☐

If seasonal or temporary resident, please indicate other address:

BIRTH DATE

EMERGENCY CONTACT_____RELATIONSHIP_____

PHONE#

WHO REFERRED YOU TO THIS PRACTICE_____

FINANCIAL RESPONSIBILITY

GUARANTOR'S LAST NAME_____FIRST_____MIDDLE _____

GUARANTOR'S ADDRESS: _____ CITY_____STATE_____ZIP_____

BIRTH DATE

EMPLOYER_____EMPLOYER PHONE#

List the name(s) and relationship(s) of those we may discuss **TREATMENT** and/or **FINANCIAL** matters with:

name: Relationship:

name: Relationship:

FINANCIAL INFORMATION

ARE YOU SELFPAY? Yes or No

NAME OF HEALTH INSURANCE COMPANY_____

PHARMACY INFORMATION

NAME: _____ PHONE

ADDRESS OR CROSSROADS: _____

CITY:_____ STATE:_____ ZIP:_____

PLEASE KEEP THIS FOR YOUR RECORDS

A NOTE TO OUR PATIENTS

We would like to take this opportunity to highlight some of our routine office practices so that we can avoid misunderstandings in the future.

1) PRESCRIPTIONS:

If you are on medication, we generally prescribe ample medication to last until your next appointment. If you return for appointments as recommended, you should not run out of medicine. **Please remember that our office does not "call in" routine prescriptions to your pharmacy between appointments**. There should be enough medication on the previous prescription until the next scheduled appointment. Please note: If the doctor feels it is appropriate to call in prescriptions under exceptional circumstances, he can only do so during routine office hours. As we do not have access to our patients' charts outside office hours, we do not feel the best medical care can be provided in this situation. Anytime you need to have a refill on a medication it is important to check if you are due for an appointment. You can check the status of any requested refills prior to the end of the working day.

2) AUTHORIZATIONS FOR MEDICATIONS:

Sometimes, your insurance company will not approve payment for a medication prescribed by Dr. Remenson, without a special authorization. For that purpose, your insurance may contact Dr. Remenson requesting to fill in forms in addition to a regular prescription that he has given you. To help you decrease your medication expenses, the doctor will do it for you. However, it takes doctor's time. If it is done outside your appointment, there may be a charge for this activity in proportion with the time spent on it. In most cases, this service is not covered by your insurance.

3) CANCELLING APPOINTMENTS:

It is important that you call to cancel existing appointments at least a full business day in advance. A specific time is allotted for appointments. We'd like to accommodate all our patients, but when a patient misses an appointment, it keeps us from being able to help everyone. Therefore you will be charged for the time that was held for your appointment. We would rather not charge you and would rather utilize the time for other patients. Once again, remember that this is 24 business hours notice for Leonid Remenson, MD and 48 hours notice for Nanette Vitale, LCSW and Patricia Conlon, LMFT. The weekend is not included. You would need to cancel Monday appointment on the prior Friday morning in order for us to try to utilize this time. Please bear in mind that we cannot bill insurance for a missed appointment and that you will be responsible for the full normal fee (not just the co-pay), and that our normal fee may be higher than your insurance fee. **We will try but we cannot guarantee that we will be able to call you and remind of follow up appointments.**

4) EMERGENCIES:

Please call between appointments if any urgent clinical matters arise. If a clinical emergency or urgent situation arises, you can call 911, go to the nearest emergency room or leave a message on Dr. Remenson's, Nanette Vitale's or Patricia Conlon's voice mail, depending on the degree of urgency. If you chose to leave a message, your call will be returned as soon as possible.

AUTHORIZATION

I AUTHORIZE L.REMENSON, M.D., P.A., ANALOGY COUNSELING, INC. amd/or PATRICIA CONLON, LMFT TO RELEASE ANY PSYCHIATRIC OR MEDICAL INFORMATION NEEDED TO AUTHORIZE MY BENEFITS OR PAYMENTS TO THE DOCTOR FOR HIS SERVICES, TO MY INSURANCE COMPANY AND THEIR AGENTS, OR MEDICARE IF APPLICABLE. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND INSURANCE BENEFITS WILL BE MADE ON MY BEHALF TO L.REMENSON, M.D. P.A., AND/OR ANALOGY COUNSELING, INC. FOR SERVICES FURNISHED BY HIM.

I UNDERSTAND THAT FAILURE TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT ONE FULL BUSINESS DAY NOTICE (24 HOURS) WILL RESULT IN THE FULL NORMAL FEE (which may be higher than my insurance fee). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE INSURANCE CARRIER. I UNDERSTAND I MAY NOT RECEIVE A CONFIRMATION CALL REMINDING ME OF MY VISIT AND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY APPOINTMENT SCHEDULE.

I UNDERSTAND THAT IF THE CHARGES FOR SERVICES BY L.REMENSON, M.D., P.A., ANALOGY COUNSELING, INC. and/or PATRICIA CONLON, LMFT ARE NOT PAID WITHIN 60 DAYS OF THE DATES OF SERVICE, I WILL BE CHARGED INTEREST ON A MONTHLY BASIS AT A RATE OF 18% ANNUALLY OR THE MAXIMUM ANNUAL INTEREST RATE PERMITTED, WHICHEVER IS LOWER. I HEREBY WAIVE CONFIDENTIALITY IF L. REMENSON, M.D., P.A. AND/OR ANALOGY COUNSELING, INC. REPORTS UNPAID SERVICES TO VARIOUS AGENCIES/COMPANIES, INCLUDING CREDIT REPORTING AGENCIES. SHOULD MY ACCOUNT BE TURNED OVER FOR COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTIONS AND/OR ATTORNEY'S FEES UP ACCESSED.

I HAVE RECEIVED A COPY OF THE **PRIVACY RULES**.

I HAVE RECEIVED AND ACCEPTED THE **NOTE TO OUR PATIENTS.**

I HAVE INFORMED L.REMENSON, M.D., P.A., ANALOGY COUNSELING, INC. and/or PATRICIA CONLON. LMFT OF MY INSURANCE COVERAGE OR LACK THEREOF. I UNDERSTAND WITH INSURANCES CONSTANTLY CHANGING, I NEED TO VERIFY WITH MY INSURANCE COMPANY THAT I AM COVERED UNDER PSYCHIATRIC CARE. I UNDERSTAND THAT IF MY INSURANCE STATUS CHANGES, IT IS MY RESPONSIBILITY TO INFORM DR. REMENSON and/or ANALOGY COUNSELING, INC., AND THERE WILL BE NO REFUND OR REIMBURSEMENT OF THE FULL NORMAL FEE PAID TO DR. REMENSON FOR SERVICES PROVIDED UP TO THE DATE OF NOTIFICATION.

I GIVE MY CONSENT TO L. REMENSON, M.D., ANALOGY COUNSELING, INC. and/or PATRICIA CONLON, LMFT AND TO MY PRIMARY CARE PHYSICIAN_____ AND MY THERAPIST _____ TO EXCHANGE THE INFORMATION AND RECORDS PERTAINING TO MY MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE EVALUATION AND TREATMENT:

Signed_____Patient's name_____

Date _____

Psychiatric (Check all that apply)

- ☐ Problems falling asleep
- ☐ waking up too early
- ☐ Problems concentrating
- ☐ sadness/depression
- ☐ decreased interest in doing things
- ☐ decreased enjoyment
- ☐ Self-reproach
- ☐ poor energy
- ☐ wanting to die
- ☐ wanting to kill yourself
- ☐ anxiety, nervousness
- ☐ Panic
- ☐ Rituals or needing things to be "just so"
- ☐ Obsessive thoughts/images
- ☐ Anger problem
- ☐ Violence
- ☐ Thoughts of hurting others
- ☐ impulsivity (acting before thinking)
- ☐ short attention span
- ☐ feeling elated
- ☐ restlessness/difficulty sitting still
- ☐ Forgetfulness
- ☐ Impatience
- ☐ Distractibility
- ☐ losing things often
- ☐ making careless mistakes when working
- ☐ problems organizing activities
- ☐ putting off projects
- ☐ feeling tense
- ☐ interrupting people often
- ☐ talking excessively
- ☐ having too much energy
- ☐ not being able to relax
- ☐ worrying excessively
- ☐ having unreasonable or excessive fears
- ☐ feeling that others are against you
- ☐ seeing things that others do not see
- ☐ hearing voices
- ☐ having a feeling that somebody is following you
- ☐ Preoccupation with weight
- ☐ binge eating
- ☐ Vomiting or using laxatives to lose weight
- ☐ starving yourself on purpose
- ☐ alcohol problem
- ☐ drug problem

NAME_____

WHY ARE YOU SEEING THE DOCTOR TODAY _____

MEDICAL HISTORY

ALLERGIES OR ADVERSE DRUG REACTIONS_____NONE ☐

MEDICATIONS (PLEASE LIST ALL THE MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS&SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING):

_____
_____
_____
_____

MEDICATIONS TAKEN IN THE PAST THREE MONTHS: _____
_____

HABITS:	CURRENT USE	PAST USE
TOBACCO	_____	_____
ALCOHOL	_____	_____
RECREATIONAL DRUGS	_____	_____

WEIGHT: _____lbs **HEIGHT: _____ft _____in**

ILLNESSES: (PAST AND PRESENT)

HEART	Yes or No	STROKE	Yes or No	BACK PAIN	Yes or No
THYROID	Yes or No	ANEMIA	Yes or No	CANCER	Yes or No
GLAUCOMA	Yes or No	REFLUX DISEASE	Yes or No	HIGH BLOOD PRESSURE	Yes or No
PROSTATE	Yes or No	LIVER PROBLEMS	Yes or No		
SEIZURES	Yes or No	LUNG DISEASE	Yes or No		
DIABETES	Yes or No	ARTHRITIS	Yes or No		

OTHER: _____
_____

FEMALES ONLY: ARE YOU PREGNANT? Yes or No PLANNING TO GET PREGNANT? Yes or No

PSYCHIATRIC HISTORY

PREVIOUS PSYCHIATRISTS/THERAPISTS: _____WHEN? _____

MEDICATIONS PRESCRIBED IN THE PAST? _____

PSYCHIATRIC HOSPITALIZATIONS? (DATES, REASONS)_____
_____

FAMILY HISTORY

PSYCHIATRIC PROBLEMS, DRUG OR ALCOHOL PROBLEMS, SUICIDE ATTEMPTS IN BLOOD RELATIVES_____

_____

Please be aware that all medications may have the potential to cause problems in pregnancy or with the developing fetus.

PLEASE KEEP THIS FOR YOUR RECORDS

Leonid Remenson, MD, PA & Analogy Counseling, INC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Our vision is to provide quality health services in a caring manner. This includes taking measures to protect the confidentiality of your personal health information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relate to your past, present or future physical or mental health or condition and related healthcare services.

We are required by law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information we maintain at that time. You may obtain the latest Notice of Privacy Practices by contacting L.Remenson, M.D., P.A., and or Analogy Counseling, INC., and requesting a revised copy be sent to you in the mail, or by asking for a copy at the time of your next appointment.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT PATIENTS

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment We may use medical information about patients to provide patients with medical treatment or services. We may disclose medical information about your condition to a physician or other healthcare provider (e.g. a specialist or psychotherapist home care agency) who, at the request of your physician, becomes involved in your care. We may also disclose medical information occasionally to our outside transcriptionist to type up medical record entries or letters.

For Payment We may use and disclose medical information to obtain payment for treatment and services provided. For example, we may need to give a patient's health plan information about a therapy session performed by Dr. Remenson and or Analogy Counseling, INC., so the patient's health plan will pay us or reimburse the patient for the costs of the treatment. We may also tell a patient's health plan about a treatment that patients are going to receive, to obtain prior approval or to determine whether a patient's plan will cover the costs of the treatment.

For health care operations: In the course of providing treatment to patients, we may perform certain important functions such as quality assessment, training programs, credentialing, medical review etc. In performing such actions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

In the course of providing treatment, pursuing payment or operating our practice, we may use or disclose your health information for the following purposes:

Appointment Reminder To contact patients who have an appointment for treatment or evaluation by Dr. Remenson and/or Analogy Counseling, INC..

Treatment Alternatives To tell patients about or recommend possible treatment options or alternatives that may be of interest to patients.

Health-Related Benefits and Services To tell patients about health-related benefits or services that may be of interest to patients.

Individuals Involved in a Patient's Care or Payment for a Patient's Care We may release medical information about a patient to a friend or family member who is involved in a patient's medical care, with written permission from the patient. We may also give information to someone who helps pay for a patient's care with written permission from the patient or a copy of the power of attorney for the patient. In addition, we may disclose medical information about a patient to an entity assisting in a disaster relief effort so that a patient's family can be notified about a patient's condition, status and location.

As Required By Law We will disclose medical information about patients when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose medical information about a patient when necessary to prevent a serious threat to a patient's health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Business associates: We may share health information about our patients with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer system, or do out billing. Our business associates are obligated to safeguard patients' health information. We will share without business associates only the minimum amount of personal health information necessary for them to assist us.

SPECIAL SITUATIONS The following special situations may result in additional uses and disclosures of health information by L.Remenson, M.D., P.A.:and/or Analogy Counseling, INC.,

Military and Veterans If a patient is a member of the armed forces, we may release medical information about that patient as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation We may release medical information about patients for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks We may disclose medical information about patients for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability. We will only make this disclosure if the patient agrees or when required by law.
- To report child abuse or neglect
- To report reactions to medications or problems with products (only patient's initials, not full name given)
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required by law.

Health Oversight Activities We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If patients are involved in a lawsuit or a dispute, we may disclose medical information about patients in response to a court or administrative order. We may also disclose medical information about patients in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will do it only with the written permission of the patient or when required by law.

Law Enforcement We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process, with written permission from the patient or when required by law
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at Dr. Remenson's and/or Analogy Counseling, INC., practice.
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime
- To Children and Family Services

Coroners, Medical Examiners and Funeral Directors We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of Dr. Remenson and/or Analogy Counseling, INC., to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities We may release medical information about patients to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others We may disclose medical information about patients to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with a patient's written permission. If patients provide us permission to use or disclose their medical information, patients may revoke that permission, in writing, at any time. If patients revoke their permission, we will no longer use or disclose medical information about patients for the reasons covered by the original written authorization. Patients understand we are unable to take back any disclosures we have already made with a patient's permission, and we are required to retain our records of the care we provided to patients.

PATIENT RIGHTS

Patients have the following rights regarding medical information maintained by L. Remenson, M.D., P..A., and/or Analogy Counseling, INC..

Right to Request Restrictions Patients may request a restriction or limitation on the medical information we use or disclose about patients for treatment, payment or healthcare operations. Patients also may request a limit on the medical information we disclose about patients to someone who is involved in a patient's care or the payment for a patient's care, like a family member or friend. For example, patients could ask that we not use or disclose information about a surgical procedure performed on the patient.

We are not required to agree to a patient's request. If we do agree, we will comply with a patient's request for restriction of use and disclosure. If the information is needed to provide emergency treatment or if it is determined that it is in the best interest of the patient to permit use and disclosure of protected health information, the request will be denied and health information will not be restricted. To request restrictions, patients must make a request in writing. In the request, patients must tell us (1) what information they want to limit; (2) whether they want to limit our use, disclosure or both; and (3) to whom they want the limits to apply, for example, disclosures to a patient's spouse. Dr. Remenson and/or Analogy Counseling, INC., has the right to request termination of the restriction at any time; the patient is required to agree to the termination either verbally or in writing.

Right to Receive Confidential Communications Patients have the right to request that we communicate with them about medical matters in a certain way or at a certain location. For example, patients can ask that we only contact them at work or by mail. To request confidential communications, patients must make a request in writing. A request must specify how or where they wish to be contacted.

Right to Inspect and Copy Patients have the right to inspect and copy medical information that may be used to make decisions about a patient's care for as long as the information is kept by or for L. Remenson, M.D., P.A..and/or Analogy Counseling, INC. Usually, this includes medical and billing records, but does not include psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; or protected health information held by clinical laboratories if prohibited by the Clinical Laboratory Improvements Amendments of 1988 (CLIA).

To inspect and copy medical information that may be used to make decisions about patients, patients must submit a request in writing. If patients request a copy of the information we may charge a fee for the costs of copying, mailing or other supplies associated with a patient's request.

We may deny a patient's request to inspect and copy information in certain very limited circumstances. For example, if the patient is under the direct care and supervision of Dr. Remenson and or Analogy Counseling, INC., it is determined that a review or inspection of the medical record may upset or harm the patient, the request can be denied. If patients are denied access to medical information, patients may request that the denial be reviewed.

Right to Amend If patients feel that medical information we have about them is incorrect or incomplete, patients may ask us to amend the information. Patients have the right to request an amendment for as long as the information is kept by or for L. Remenson, M.D., P.A. and/or Analogy Counseling, INC..

To request an amendment, a patient's request must be made in writing. In addition, patients must provide a reason that supports the request.

We may deny a patient's request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny a patient's request if patients ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information kept by or for L. Remenson, M.D., P.A. and or Analogy Counseling, INC..
- Is not part of the information which patients would be permitted to inspect
- Is accurate and complete

If your request for amendment is denied, we will notify you in writing along with the reasons for denial.

Right to an Accounting of Disclosures Patients have the right to request an "accounting of disclosures." This is a list of the disclosures that we made of medical information about patients beyond the uses and disclosures described in this notice. To request this list or accounting of disclosures, patients must submit a request in writing. A patient's request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list patients request within a 12-month period will be free. For additional lists, we may charge patients for the costs of providing the list.

Right to a Paper Copy of This Notice: Patients have the right to a paper copy of this notice. Patients may ask us for a copy of this notice at any time from L. Remenson, M.D., P.A. and/or Analogy Counseling, INC. at 561-638-9219.

COMPLAINTS

If a patient believes their privacy rights have been violated, patients may file a complaint with Dr. Remenson and/or Analogy Counseling, INC. or with the Secretary of the United States Department of Health and Human Services (HHS). To file a complaint with Dr. Remenson and or Analogy Counseling, INC., submit the complaint in writing to his office. To file a complaint with the Secretary of HHS, the patient must contact the Office for Civil Rights directly (see Cont Analogy Counseling, INC., act Information below).

Patients will not be penalized for filing a complaint. L. Remenson, M.D., P.A.and/ or Analogy Counseling, INC., is committed to protecting an individual's rights under HIPAA and at no point will require an individual to waive their right to file a complaint as a condition of the provision of treatment.

CONTACT INFORMATION

Leonid Remenson, MD
Analogy Counseling, INC., Nanette Vitale, LCSW
5350 W. Atlantic Ave, Suite 106
Delray Beach, FL 33484
561-638-9219

U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)
Region IV - Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)
Roosevelt Freeman, Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (404) 562-7886 FAX (404) 562-7881 TDD (404) 331-2867
http://www.hhs.gov/ocr/

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

PLEASE JUST SIGN HERE AND HERE

NO NEED TO FILL THE REST

(WE NEED TO HAVE YOUR SIGNATURE ON FILE TO BILL YOUR INSURANCE)

14. DATE OF CURRENT: MM | DD | YY

17. NAME OF REFERRING PH

19. RESERVED FOR LOCAL U

21. DIAGNOSIS OR NATURE (

1. ____ . ___

2. ____ . ___

...TIENT UNABLE TO WORK IN CURRENT OCCUPATION ... MM | DD | YY TO MM | DD | YY

...IZATION DATES RELATED TO CURRENT SERVICES ... MM | DD | YY TO MM | DD | YY

...LAB? $ CHARGES

S NO

...RESUBMISSION ORIGINAL REF. NO.

...ITHORIZATION NUMBER

24. A

DATE(S) OF SER From MM DD YY	To MM DD YY	of Service	of Service	(Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	CODE	$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

C1502BC

InHealth Record Systems (div. of Professional Filing Systems, Inc.)
To Order Call 1-800-477-7374, In Atlanta 770/396-4994

APPROVED OMB-0938-0008

Leonid Remenson, MD

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider, Leonid Remenson, MD, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider, Dr. Leonid Remenson, MD, may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Dr. Leonid Remenson, MD. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Patient Name _____ Patient DOB

_____Signature of Patient or Guardian _____Today's Date

_____Relationship to Patient

PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy):_____

Address: _____City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name:_____ Phone: (____)_____

Address:_____ Fax: (____)_____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- I understand this authorization releases my general medical information as well as information concerning (if any) psychiatric treatment. I also understand if my medical information contains treatment notes, diagnosis and/or test results of Acquired Immune Deficiency Syndrome (AIDS), HIV and/or related conditions, and/or substance abuse, these medical records shall also be released
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

_____ Initials _____ Date

Explanation of Form Florida
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.