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?

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. 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 or Nanette Vitale'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. and/or ANALOGY COUNSELING, INC. 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. and/or ANALOGY COUNSELING, INC. 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. and/or ANALOGY COUNSELING, INC. 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., P.A., AND/OR ANALOGY COUNSELING, INC. AND TO MY PRIMARY CARE PHYSICIAN ________________________________ (NAME) AND MY THERAPIST _____________________________ (NAME) TO EXCHANGE THE INFORMATION AND RECORDS PERTAINING TO MY MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE EVALUATION AND TREATMENT:

MUST FILL AREAS BELOW

Signed____

Patient's name____

Dated_________________________________

PLEASE CHECK PROBLEMS THAT YOU HAVE:

Immunologic/Allergy:
___watery eyes
___ Frequent infections
___ Allergies
___ Other
___ No problems

Breathing:
___ Cough
___ Difficulty breathing
___ wheezing
___other
___ no problems

Cardiovascular:
___ Palpitations
___ Shortness of breath on exertion
___ cramps when walking
___ Gangrene
___ Other:
___ no problems

General well-being:
___ Fatigue
___ Fever
___ unexplained weight loss
___other:
___ no problems

Skin/hair/nails:
___ Itchiness
___ Rash
___ Hair loss
___ Other:
___ no problems

Endocrine:
__ Excessive thirstiness
__ Excessive urination
__Other:
__ No problems

Ears/Nose/Throat:
___ Sore throat
___ Hearing problem
___ Runny nose
___ other:
___ no problems

Reproductive system:
___ decreased sex drive
___Problems with erection
___ No orgasm
___ other:
___ No problems

Stomach:
___ Nausea
___constipation
___ vomiting
___ Heartburn
___ Poor appetite
___ Other:
___ No problems

Blood/lymph system:
__Easy bleeding/bruising
__Lymph node swelling
__Other:
__ No problems

Musculoskeletal:
___ Joint swelling/pain
___ Muscle aches
___ Bone deformities
___ Other:
___ No problems

Neurological:
___ Problems moving, paralysis
___ Numbness/tingling
___ Gait problems
___other:
___ No problems

Eyes:
___ Watery eyes
___ blurred vision
___ Need glasses
___ Eye irritation
___ other
___ No problems

GU:
___ Blood in urine
___ difficulties./burning on urinating
___ Female problems
___ Incontinence
___ other
___ No problems

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
THYROID
GLAUCOMA
PROSTATE
SEIZURES
DIABETES
OTHER: _

STROKE
ANEMIA
REFLUX DISEASE
LIVER PROBLEMS
LUNG DISEASE
ARTHRITIS

BACK PAIN
CANCER
HIGH BLOOD PRESSURE

FEMALES ONLY: ARE YOU PREGNANT? PLANNING TO GET PREGNANT?

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).

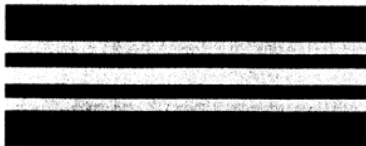
Patients will not be penalized for filing a complaint. L. Remenson, M.D., P.A.and/ or Analogy Counseling, INC., is committed to protecting an individual's rights under HIPAA and at no point will require an individual to waive their right to file a complaint as a condition of the provision of treatment.

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



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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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? PLACE (State) YES NO

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

14. DATE OF CURRENT: MM | DD | YY

PLEASE JUST SIGN

HERE AND HERE

NO NEED TO FILL THE REST

(WE NEED TO HAVE YOUR SIGNATURE

ON FILE TO BILL YOUR INSURANCE)

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

17. NAME OF REFERRING PH

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

19. RESERVED FOR LOCAL U

LAB? $ CHARGES S NO

21. DIAGNOSIS OR NATURE (

1. ___ . ___

RESUBMISSION ORIGINAL REF. NO.

2. ___ . ___

THORIZATION NUMBER

24. A DATE(S) OF SER From MM DD YY	To MM DD YY	of Service	of Service	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#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

C1502BC

PLEASE PRINT OR TYPE

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

InHealth Record Systems (div. of Professional Filing Systems, Inc.)
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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