UPPER EASTSIDE INTERNAL MEDICINE

REGISTRATION FORM

(Please Print)

Today's date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /		Age:
Street address:		Apartment #:	Sex: □ M □ F		
P.O. box:	City:	State:	ZIP Code:		
Social Security no:	Cell #: ( )	Home Phone #: ( )			
Occupation:	Employer:	Employer phone no.: ( )			
Chose office because/Referred to office by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Zocdoc ❑ Other					
Email Address:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate insurance accepted by Physician ❑ Aetna ❑ Cigna ❑ Empire Blue Cross Blue Shield ❑ Humana ❑ 1199 ❑ Oscar ❑ Oxford ❑ United Healthcare ❑ Medicare ❑ Empire Plan ❑ Other _____					
Subscriber's name:	ID #.:	Birth date: / /	Copay: $	Group #:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	ID #:	Group no.:			
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Upper eastside internal medicine or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

(Please Print)

PAYMENT

*EFFECTIVE AS OF JANUARY 1, 2019

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payment and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contact with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable by Medicare or other insurers. Once statement is received, payment must be made in full.

4. **Prof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy if your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not part to that contract.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed Appointments.** Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly schedule appointment. A "NO SHOW" fee will be applied per date of service to your account if you do not cancel your appointment within 24 hours.

9. **Medical Records.** Please note that any balance you have must be paid in full prior to sending out medical records (to other physicians, lawyers, etc).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

Patient/Guardian signature *Date*

LAB WELLNESS SCREENING CONSENT

*EFFECTIVE AS OF JANUARY 1, 2019

By signing your consent, you:

1. Allow your blood to be drawn and provide a urine sample.
2. Request to be tested.
3. Understand that your lab results along with the physician's interpretations will be mailed to you at the address you have provided to your physician.
4. Understand that your lab results will be made a part of your medical record or patient chart.
5. Understand that labs are a separate entity from this office and any questions pertaining to labs contact the facility directly.
6. Accept our privacy practices.
7. Consent to follow-up testing if an exposure to your blood occurs.

Please make your selection by marking only one box below:

- ○ One-time testing
- ○ Ongoing Monitoring (form valid for one year from date of signature below)

Patient/Guardian signature *Date*

HIPAA NOTICE OF PRIVACY PRACTICES

*EFFECTIVE AS OF JANUARY 1, 2019

This Notice of Privacy Practices describes how we use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

By my signature below, I hereby consent to use or disclose of my health information in order that Leon Scrimmager MD may provide treatment, obtain payment for the treatment or carry out its healthcare operations. I understand that this consent only gives Leon Scrimmager MD a more limited right to use any highly confidential health information contained in psychotherapy notes or about: (1) mental health and developmental disabilities; (2) substance abuse; (3) HIV/AIDS testing; (4) genetic testing's; (5) child abuse and neglect; and (6) communicable disease. For purposes of this consent, health information includes any and all information relating to the healthcare services provided to me prior the date of consent.

I understand that Leon Scrimmager MD has a notice of privacy practices that explains, among other things, the definition of treatment, payment, and health care operations and the types of use or disclosure that Leon Scrimmager MD can make if I sign this consent. I understand that I have the right to review the notice before I sign consent. I further understand that Leon Scrimmager MD may charge the terms of the notice from time to time but that any such changes will be in accordance with the Federal and state laws governing the use and disclosure of health information, including any highly confidential health information. I understand that I may contact the "privacy office" at the listed address below to obtain a revised version of the Notice at any time.

I understand that I may at any time submit a request in writing to the privacy office, at the address listed below to request that Leon Scrimmager MD restrict how my health information is used or disclosed to carry out treatment, obtain payment or carry out health care operations. I understand that Leon Scrimmager is not required to agree to my request or restrictions, however, the restrictions will be binding on Leon Scrimmager MD.

I understand that this consent will remain in effect until I provide a written notice a revocation to the Privacy Office at the address listed below. The revocation will be effective immediately upon the receipt by Leon Scrimmager MD of my written notice:

The address of Privacy Office is as follows: Leon Scrimmager MD, 470 Lenox Ave, Suite 1P, New York, NY 10037, Phone: 212-249-1627.

I understand that if I refuse to sign this consent or if I revoke this consent in the future that Leon Scrimmager MD may not provide any treatment to me or arrange for treatment on my behalf except under certain emergencies or if otherwise required by law.

Patient/Guardian signature *Date*

WELLNESS HISTORY

*EFFECTIVE AS OF JANUARY 1, 2019

TODAY'S VISIT

What brings you to the office today?_____

How is your general health? EXCELLENT GOOD FAIR POOR

Is there anything else you'd like to work on to improve your health?

_____

If you have one of the following conditions, please circle answer:

Diabetes: Any problems with medications? YES NO

High Blood Pressure: Any problems with meds? YES NO

High Cholesterol: Any problems with meds? YES NO

Depression: Any problems with meds? YES NO

BETWEEN VISITS

Have you been to the ER, hospital, or another doctor? YES NO

If yes, please explain: _____

LIFESTYLE

How often do you exercise? _____

Can you walk a block or climb a flight of stairs without getting short of breath? YES NO

Have you ever smoked? YES NO # of years_____ # of packs_____

Do you smoke now? YES NO # of packs/day_____

Are you interested in quitting? YES NO

Do you use recreational drugs? YES NO types?_____ # of times/week_____

How much alcohol do you drink per week? _____

Are you or others concerned about your drinking? YES NO

Have you fallen in the past year? YES NO

Do you have problems with walking or balance? YES NO

Are you in a relationship where you feel unsafe or have been hurt? YES NO

Are you sexually active? YES NO # of partners in past year_____

Do you wish to be checked for STDs? YES NO

Would you like HIV testing? YES NO

How much caffeine do you drink per day? (e.g., coffee, tea, chocolate, soda) _____

Birth control method (if applicable) _____

Do you stop breathing during sleep or have concerns about sleep apnea? YES NO

Over the last 2 weeks have you been bothered by little interest or pleasure in doing things, or feeling down, hopeless, or depressed? YES NO

What medications are you currently taking?

_____

_____

_____

Do you have any trouble taking any of your medications? YES NO

If so, what sort of trouble?

_____

_____

Do you lose control of your urine to the point you like to know how to treat it? YES NO

UPDATE

Please identify any issues below which are new or that you specifically want to address:

Has anything new come up in you family history?

Constitutional symptoms: FEVER WEIGHT LOSS EXTREME FATIGUE

Eyes: DOUBLE VISION SUDDEN LOSS OF VISION

Ears, nose, mouth, and throat: SORE THROAT RUNNY NOSE EAR PAIN

Cardiovascular: CHEST PAIN PALPATATIONS

Respiratory: COUGH WHEEZING SHORTNESS OF BREATH

Gastrointestinal: NAUSEA VOMITTING ABDOMINAL PAIN CONSTIPATION DIARRHEA BLOOD IN STOOLS

Genitourinary: IRREGULAR MENSES VAGINAL BLEEDING AFTER MENOPAUSE FREQUENT/PAINFUL URINATION IMPOTENCE BLOODY URINE

Skin: RASH CHANGING MOLE

Sleep: SNORING DIFFICULTY SLEEPING

Neurological: HEADACHE PERSISTENT WEKANESS OR NUMBNESS ON ONE SIDE OF THE BODY FALLING

Musculoskeletal: JOINT PAIN MUSCLE WEAKNESS

Psychiatric: DEPRESSION ANXIETY SUICIDAL THOUGTHS

Endocrine: EXCESSIVE thirst COLD OR HEAT INTOLERENCE BREAST MASS

Hematologic: UNUSUAL BRUISING/BLEEDING ENLARGED LYMPH NODES

Allergies: _____

_____ _____

Patient/Guardian signature *Date*