Internal Medicine of Greater New Haven
Patient Registration Form

Home phone_____ Work phone _____
Cellular phone_____ Email_____

Date ___/___/____

Patient Information			
Patient Name (first, last)	Sex	Marital Status	Date of Birth (mm/dd/yyyy)
Address:	City	State	Zip code
Social Security number	Employer Name		
Race:	Ethnicity:	Language spoken	
Emergency contact Name:	Relationship to patient	Emergency contact phone number	
Pharmacy:	Address	Tel.	

Primary insurance information	
Insurance company name	Insurance co. phone number
Subscriber's name & relationship to patient	Subscriber's identification number
Subscriber's group name or number	Subscriber's employer name

Secondary insurance information	
Insurance company name	Insurance co. phone number
Subscriber's name & relationship to patient	Subscriber's identification number
Subscriber's group name or number	Subscriber's employer name

RELEASE OF IN FORMATION:

I authorize Internal Medicine of Greater New Haven to release all medical records to the referring physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

ASSIGNMENT OF INSURANCE BENEFITS:

I fully authorize and request that insurance payment be made directly to Internal Medicine of Greater New Haven.

FINANCIAL RESPONSIBILITY:

I acknowledge full financial responsibility for services rendered by Internal Medicine of Greater New Haven and authorize transfer of all unpaid amounts to my Visa/ MasterCard, where applicable, after 120 days from date of service. If it becomes necessary for Internal Medicine of Greater New Haven to engage the services of an Attorney or Collection Agency to collect balances due, I agree to pay lawful and reasonable Attorney's fees, collection fees or court costs. Coverage for your services is determined by your policy's benefits. You may be responsible for a variety of treatments, including but not limited to: **PREVENTATIVE PHYSICAL EXAMINATION** (yearly routine physical), **COLORECTAL CANCER SCREENING; FECAL-OCCULT BLOOD TEST, VACCINATIONS** (i.e. Influenza, etc.), **INJECTABLES** (i.e. Vitamin B12, etc.), **DIAGNOSITIC IMAGING(** i.e. Ultrasounds and Bone Density). I have been notified by my Physician that He/She believes that my insurance may/can deny payment for the services. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Signature_____

INTERNAL MEDICINE OF GREATER NEW HAVEN, LLC
WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICE AND PHARMACY PRACTICES

Patient Name_____
Date of Birth_____

I, hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact HIPAA Privacy Officer of Internal Medicine of Greater New Haven.
I also understand that I am entitled to receive updates upon request if the Internal Medicine of Greater New Haven LLC Notice of Privacy Practices is amended or changed in a material way.

An electronic pharmacy system will be used permitting the viewing of your medication history from external sources, i.e. the Pharmacist and pharmacy staff at your selected pharmacy.

Signature:_____ Date:_____

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

On_____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

- o Patient declined to sign this Written Acknowledgement.
- o Patient did not understand the request to sign the Acknowledgement.
- o Other_____

Name and Title of Employee_____ _____
Date:_____

I permit Internal Medicine of Greater New Haven to:

- o Leave messages reminding me of appointments.
- o Leave messages regarding missed laboratory or diagnostics imaging.
- o Leave messages regarding billing, balances and other insurance information.
- o Leave messages regarding normal laboratory/diagnostic imaging results.

Internal Medicine of Greater New Haven
1952 Whitney Ave. Hamden, CT 06517
203-848-1803

Patient Name: Date of Birth:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the services below.

Services provided	Reason Medicare May Not Pay:	Estimated Cost
• Preventative physical examination(yearly routine physical) • Colorectal Cancer Screening; Fecal-Occult Blood Test (covered ONLY once per calendar year) • Vaccinations (except Flu and Pneumonia shots)	• Medicare does not usually pay for these services • Medicare does not usually pay for these shots • Medicare usually does not pay for this lab test • This procedure is not covered under Medicare's policy Beneficiary Notice	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.
  Note: If you choose Option 1or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

AUTHORIZATION TO RELEASE INFORMATION

Patient name:	Date of birth:
Doctor/Facility Name:	
Address:	

I hereby authorize this practice to make use and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below.

This information is to be disclosed to:

Internal Medicine of Greater New Haven
1952 Whitney Avenue
Hamden, CT 06517
(203) 848- 1803 phone (203) 848- 1777 fax

Description of information to be disclosed: Medical Records

Reason for requested use of disclosure: Patient Care

TO BE READ AND SIGNED BY PATIENT

I understand the following:

a) I may revoke this authorization at any time by providing written notice to the practice.
b) I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c) The practice will not condition treatment or payment based on m signing this authorization.
d) I am signing this authorization freely.
e) No one has pressured me to sign this authorization.
f) The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by law.
g) I acknowledge that I have had opportunity to review this authorization and understand the intent and the use.
h) I have received a copy of this authorization.

Patient signature:		Date:
Signature of patient's representative:	Relationship to patient:	Date:

FOR OFFICE USE ONLY

Event or date upon which authorization will expire

INTERNAL MEDICINE OF GREATER NEW HAVEN, LLC
1952 Whitney Avenue | Hamden, CT 06517
T: 203-848-1803 F: 203-848-1777

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me including the following:

- Access to my care team 24-hours-a-day, 7 days-a-week, including telephone access and other non-face-to-face means of communication (e.g., email),
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventative care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:

  Referrals to other health care providers
  Follow-up after I visit an emergency department
  Follow-up after I am discharged from the hospital or other facility (e.g. skilled nursing)

- Coordination with home-and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish my chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that INTERNAL MEDICINE OF GREATER NEW HAVEN, LLC is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____

Patient or guardian signature: _____

Declining services: _____