Ninth Avenue Internal Medicine, LLC

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date:_____

Patient Name: _____ _____
Last *First* *MI* *Home Phone*

_____
Cell Phone

Home Address: _____ Mailing Address:_____
Street *Street*

_____ _____ _____ _____ _____ _____
City *State* *Zip* *City* *State* *Zip*

DOB:_____ Age:_____ ☐M ☐F SS#_____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex *Marital Status*

E-mail _____ Emergency Contact_____

Responsible Party:_____ _____
Name *Relationship* *Contact Phone*

Race: Ethnicity: _____ Language:_____

Referring Physician:_____ Primary Care Physician:_____

How did you hear about us? _____

Primary Ins:_____ Phone:_____

Insured Name:_____ DOB:_____ Group #:_____ Policy #:_____

Secondary Ins:_____ Phone:_____

Insured Name:_____ DOB:_____ Group #:_____ Policy #:_____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to NAIM, LLC. I also authorize agents of any hospital, treatment center or previous physicians to furnish NAIM, LLC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance career as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within NAIM, LLC.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to NAIM, LLC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to NAIM, LLC.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies hat produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with NAIM, LLC.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Relationship Date

Employee Initials_____

For Office Use Only
CONFIDENTIAL
Copies to – Medical Record and Patient

Ninth Avenue Internal Medicine, LLC

Ninth Avenue Internal Medicine, LLC
4500 East Ninth Avenue, Suite 140 Denver, CO 80220
Phone (303) 394-2152 Fax (303) 394-2496

HISTORY AND PHYSICAL FORM, NEW PATIENT

Welcome to our practice. Please fill in the blanks with your information. The information below will help our doctors. Thank you.

Date _____

Name _____
Last, First

Date of birth _____ **Social security number:**_____

Chief Complaint: _____
_____

Is your visit today result of the injury or motor vehicle accident? □ Yes □ No
Are you having a surgery soon and this is a preoperative visit? □ Yes □ No
If yes, please specify _____

Past Medical History:

Head, Eyes, Ears, Nose & Throat
□ Cataract
□ Glaucoma
□ Poor vision
□ Ear infections (frequent)
□ Ringing
□ Hearing problems
□ Sinus problems
□ Nose bleeds
□ Sore throat (frequent)
□ Other (specify) _____

Respiratory System:
□ Asthma
□ Emphysema/COPD
□ Pneumonia
□ Pulmonary hypertension
□ Other (specify) _____

Cardiovascular System
□ Heart attack_____
□ Coronary artery disease
□ Irregular heartbeat
□ Heart murmurs
□ Congestive heart failure
□ High blood pressure
□ High cholesterol
□ ICD or □ Pacemaker
□ Peripheral vascular disease
□ Syncope
□ Stress test or angiogram_____
□ Other (specify) _____

Genitourinary Systems
□ Kidney stones
□ Prostate problems
□ Urinary incontinence
□ Renal insufficiency/failure
□ Hemodialysis
□ Frequent urinary infections
□ Urethral/Vaginal discharge
□ Venereal disease (STD)
□ Sexual/Erectile dysfunction
□ Menstrual dysfunction/ infertility
□ Other (specify) _____

Tumors/ Blood disorders
□ Blood clots
□ Bleeding/ Easy bruising
□ Anemia
□ Leukemia/lymphoma
□ Lung cancer
□ Breast cancer
□ Prostate cancer
□ Colon cancer
□ Skin cancer
□ Other (specify) _____

Neurological:
□ Migraine headaches
□ Seizures
□ Stroke
□ Chronic tremor /Parkinson's
□ Other (specify) _____

Digestive System:
□ Peptic ulcer
□ Gastroesophageal reflux/ Heartburn
□ Hiatal hernia
□ Difficulty swallowing
□ Loss of appetite/ Nausea/ Vomiting
□ Hepatitis/ Jaundice
□ Gall bladder problems
□ Pancreatitis
□ Chronic diarrhea
□ Chronic constipation
□ Bleeding (GI tract)
□ Diverticulosis □ Diverticulitis
□ Inflammatory bowel disease
□ Irritable bowel syndrome
□ Lactose intolerance
□ Polyps
□ Hemorrhoids
Last colonoscopy: _____
□ Normal □ Abnormal
□ Other (specify) _____

Female only:
Pregnant □ Yes □ No
Periods □ Regular □ Irregular □ Painful
Days of flow___ Length of Cycle___
Pregnancies___ Abortions___
Miscarriages___ Live Births___
Birth control method _____
Last PAP test ____/____/_____
□ Normal □ Abnormal
□ Menopause
Last mammogram _____
□ Breast lump □ Normal □ Abnormal

Muscular:
□ Muscular weakness
□ Numbness/ Tingling
□ Chronic back pain
□ Chronic neck pain
□ Arthritis/Joint pain
□ Gout
□ Osteoporosis
□ Broken bones (list) _____
□ Other (specify)_____

Endocrine:
□ Diabetes
□ Thyroid disease
□ Steroids dependent conditions
□ Early menopause
□ Osteoporosis
□ Other (specify) _____

Vascular
□ Varicose veins
□ Claudication (leg pain with walking)
□ Deep venous thrombosis
□ Carotid stenosis
□ Other (specify) _____

Mental:
□ Anxiety
□ Memory loss
□ Insomnia
□ Anorexia
□ Bulimia
□ Depression
□ Bipolar disorder
□ ADHD
□ Other (specify)_____

Surgical and Hospitalization History:

Diagnosis or Procedure	Date performed	Hospital	Physician (Surgeon)	Details

Pharmacy used:

Pharmacy: _____
Phone number: _____

Oxygen/Medical equipment companies used:

Name, phone number: _____

Medications used:

Medication (name)	Dose	Frequency

Medication allergies:

1)_____ 4)_____
2)_____ 5)_____
3)_____ 6)_____

Food allergies: _____

Family History (indicate relationship)	**Social history:**
□ Heart attack/ Coronary artery disease_____	**Marital Status:** **Occupation:**
□ Alzheimer's disease_____	□ Single □ Married _____
□ Familial hyperlipidemia_____	□ Divorced □Widowed
□ Stroke_____	**Alcohol:**
□ Cancer (specify)_____	☐Yes _____drinks per day/week/month
□ Diabetes_____	☐No ____
□ Thyroid disease_____	☐Quit in_____
□ Blood clots_____	☐ **Tobacco/** □ **Marijuana use**:
□ Psychiatric/mental conditions_____	☐Yes ____cigs/day ____years
□ Seizure disorder_____	☐No
□ Other (specify) _____	☐ Quit in_____

Vaccinations received:

□ Tetanus, Td or Tdap _____
□ Influenza _____
□ MMR _____
□ Hepatitis B _____
□ Hepatitis A _____
□ Varicella _____
□ Zostavax _____
□ Gardasil _____
□ Meningitis _____
□ Pneumovax _____
□ Other (specify)_____

Ninth Avenue Internal Medicine, LLC

Ninth Avenue Internal Medicine; LLC
4500 E. 9th Ave Suite 140 Denver, CO 80220
P. 303.394.2152 F.303.394.2496

There is a $_____ yearly deductible and/or $_____ co-insurance/co-pay on my health insurance policy.

Please have my Credit Card on record in order to cover any portion of my deductible/ co insurance or co-pay, or any outstanding balances that will be determined by my insurance company. I agree for this card to be charged in accordance with my Credit Card Agreement and understand that a receipt for said charges will be mailed to the address I have left on file with this office. I will notify the office on any changes to this Credit Card.

Visa ☐ Master Card ☐ AmEx ☐ Discover ☐ Care Credit ☐

Card # _____ Ex Date: ____/____ Code _____

Patient Name _____

Patient Signature: _____ Date : _____

Ninth Avenue Internal Medicine, LLC

Authorization for Release of Medical Records

I, _____, authorize Ninth Avenue Internal Medicine, LLC to receive a copy of my Medical Records, including the following items:

_____

_____

_____

The purpose of this disclosure is for: _____

Information may be released from the following physician offices:

_____

_____

_____

Please send copies to:

Ninth Avenue Internal Medicine, LLC
4500 E. 9th Avenue, Suite 140
Denver, CO 80220
Phone: 303-394-2152
Fax: 303-394-2496

1. I understand this authorization will expire, without my express revocation, one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
2. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.
3. I understand that any information disclosure has the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
4. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy or facsimile of this consent is as valid as the original. I understand that I might be denied service if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. At my request a copy of this form will be provided to me.

_____ _____
Patient Signature Date

_____ _____
Date of Birth Social Security Number

If you have any questions please contact Ninth Avenue Internal Medicine at the above number.

Ninth Avenue Internal Medicine, LLC

Patient Name _____

CONTACT LIST

Contact Name: _____ _____
Last First Telephone

Address:

_____

_____
City State Zip

☐Spouse ☐Family (Describe) _____ ☐Friend ☐Emergency ☐Other

Contact Name: _____ _____
Last First Telephone

Address:

_____

_____
City State Zip

☐Spouse ☐Family (Describe) _____ ☐Friend ☐Emergency ☐Other

1. I hereby authorize Ninth Avenue Internal Medicine, LLC to use and disclose my personal health information to the individuals identified on this form.
2. I understand that the individuals identified on this form will be treated by Ninth Avenue Internal Medicine, LLC as individuals involved directly in my care and as such Ninth Avenue Internal Medicine, LLC will be allowed to release my personal health information to these individuals for the purpose of treatment, payment and healthcare operations.
3. I understand that I have a right to request and receive a Notice of Privacy from Ninth Avenue Internal Medicine, LLC.

THIS AGREEMENT CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statement and accepted the terms. A duplicate of the statement is considered the same as the original.
I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ninth Avenue Internal Medicine, LLC will not be affected if I refuse to sign this authorization.

_____ _____
Patient or Personal Representative Signature Date/Time

Ninth Avenue Internal Medicine, LLC

Drs. Igor Borisov, MD and Daniel Witten, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ninth Avenue Internal Medicine, LLC is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately, This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

_____(INITIAL HERE) I acknowledge that I have received a copy of the This Notice of Privacy Practices of Ninth Avenue Internal Medicine, LLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF COLORADO MEDICAL ARBITRATION PROGRAM

_____(INITIAL HERE) I acknowledge that I have read the Colorado Medical Arbitration Program Agreement and agree that any claim I may have in the future against the doctor and Ninth Avenue Internal Medicine; LLC or any derivative claim arising out of the same incident will be resolved by arbitration rather that in court trial by judge and jury.

Patient or Personal Representative Name (Print):_____

Patient or Personal Representative Signature: _____

Date: _____

For Office Use Only:

Reason acknowledgement was not obtained:

_____

_____

_____

EMPLOYEE INITIAL

Ninth Avenue Internal Medicine, LLC

NO SHOW POLICY

Due to the rising cost of serving your medical needs, we find that we must charge out patients for "no-show appointments." The fee for this charge can be up to $150 per visit.

Please understand that when you schedule an appointment and do not show up or cancel ahead of time, we cannot just "stick" someone else in your appointment slot. Therefore, we are requiring that our patients give us **24 hours** notice that they need to cancel or reschedule an appointment. If we do not receive notice prior to **24 hours** before your scheduled appointment we can and will bill you directly for the visit and will use all options available to us in an effort to collect those charges.

Thank You in advance for your understanding.

_____ _____

Patient/ Guardian Signature Date

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