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.

Signature____

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

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.

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, LLC
WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE-PHARMACY

Patient Name____

Date of Birth____

Dear Patient,

We will be using an electronic pharmacy system that will permit the viewing of you 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:

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

Name and Title of Employee_______________________________________
Date:_________________________

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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Internal Medicine of Greater New Haven
Waiver of Liability

PHYSICIAN NOTICE

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 identified above, for the reason stated. If my insurance denies payment, I agree to be personally and fully responsible for payment."

Patient Name: ______________________________

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

ADVANCED DIRECTIVE DECLARTATION

I, ________________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become unable to make my own health care decisions. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of dying if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain even if those measures may hasten my death. In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment.

I DO	I DO NOT	
☐	☐	want cardiac resuscitation (CPR)
☐	☐	want mechanical respiration (breathing machine)
☐	☐	want tube feeding (artificial)
☐	☐	want invasive diagnostic tests
☐	☐	want antibiotics
☐	☐	other:

HEALTH CARE PROXY

I, ____________________ hereby appoint ____ ____ as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when I become unable to make my own health care decisions. I ask that my agent make decisions in accord with my wishes and limitations as stated above. Unless I revoke it, this proxy will remain in effect indefinitely or until the following date: ____________________

Substitute health care agent (name and address)

____

I made this declaration on the _______ day of ____________ in the year ____________________
Signature: ______________________________ Address:

____

____

The above names individual knowingly and voluntarily signed this document in my presence.

Witness Signature____________________ Witness Signature______________________

Name & Address____________________ Name & Address______________________

____________________ ______________________

Pre – Appointment Questionnaire

Name: ______________________________ Date _______________

To help us get the most out of today's visit please answer the following questions:

What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be).

____

____

Are you experiencing any of the following symptoms in relation to your main concern? (Answer "yes" by circling the appropriate symptom).

Constitutional symptoms: fever, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision

Ears, nose, and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitations

Respiratory: cough, wheezing, shortness of breath

Skin: rash, changing mole

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stool

Musculoskeletal: joint pain, muscle weakness

Genitourinary: irregular menses, vaginal bleeding after thoughts menopause, frequent/painful urination, incontinence

Psychiatric: depression, anxiety, suicidal

Neurological: headache, persistent weakness or numbness, on one side of the body, falling

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Allergic: hay fever

Do you have any other concerns?

____

Has anything new come up in your family history? (example: have any of your blood relatives recently developed a new illness?)

____

Have you developed any new drug allergies?

____

What do you do for exercise: ______________________ How long? __________ How often? _________

(Note: Brisk walking for 30 minutes most days is associated with a 30% reduction in risk of heart attacks.)

How much tobacco do you smoke of chew per day?

____

(Note: It is recommended that you stop using tobacco. We can provide tobacco-cessation counseling.

How much alcohol do you consume per week? ______________________

How much caffeine do you consume per day? (i.e. tea, coffee, chocolate, soda)

____

What method of birth control to you use? Not applicable, the pill, vasectomy, tubal ligation, Other:

____

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: ______________________________

Date: ________________

Patient Questionnaire

Name:______________________________ Date of Birth: ____________________

1. When and where did you have your last **mammogram**? (3014F)
   Date: ____________________ *Location/Facility:* ____________________
   ☐ Does not apply

2. When and where did you have your last **colonoscopy**? (3017F)
   Date: ____________________ *Location/Facility:* ____________________
   ☐ Does not apply

3. When and where did you have your last **influenza** (flu) **vaccine**? (4037F or G8482)
   Date: ____________________ *Location/Facility:* ____________________

4. When and where did you have your last **pneumonia vaccine**? (4040F; Walgreens/CVS, previously given).
   Date: ____________________ *Location/Facility:* ____________________
   ☐ Does not apply

5. If you are a **diabetic**, when and where was your last **eye exam**? (2022F within 1 year, 3072F within 2 years)
   Date: ____________________ *Location/Facility:* ____________________
   ☐ Does not apply

INTERNAL MEDICINE OF GREATER NEW HAVEN, LLC
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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ☐ Date: ☐

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all 0	Some Days 1	Most Days 2	Nearly every day 3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling asleep or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could notice; or the opposite, being so fidgety or restless that you have been moving around more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Total Score: ☐

Interpretation

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately Severe Depression
- ☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal Depression
- 5-9 Mild Depression
- 10-14 Moderate Depression
- 15-19 Moderately severe depression
- 20-27 Severe Depression

*************SCORE OF 5 OR ABOVE NEEDS AN APPOINTMENT IN 3 MONTHS. A SCORE OF 9 AND ABOVE NEEDS AN APPOINTMENT IN 3 MONTHS AND THEN AGAIN IN 1 YEAR OF THE ORIGINAL PHQ9***************