Bestcare Internal Medicine

PATIENT REGISTRATION

PLEASE PRINT

Today's Date: _____

Rendering Provider (PCP): ☐ Dr. Barbara Bialowolska-Romaniuk, MD ☐ Catherine Krings, NP ☐ Izabela Musial, MD ☐ Lorraine Stevens, PA

LAST NAME _____ FIRST NAME _____ MI _____

Date of Birth _____ Social Security No. _____ Sex: ☐ Male ☐ Female

Email _____ (by providing an email, I consent to receive email communication from our office)

(We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without your permission, and do not send spam.

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Legally Separated ☐ Partner ☐ Unknown

Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Cell Phone No. _____

Work Phone No. _____ Ext. _____

Pharmacies: (Retail)
Name: _____
Cross Streets: _____
Phone No.: _____
Fax No.: _____
City: _____

(Mail Order)
Name: _____
City: _____
Phone No.: _____
Fax No.: _____

☐ **OK to leave message at home** ☐ **OK to leave message on cell phone**

Previous PCP: _____ Tel. #: _____ Fax #: _____

Ethnicity _____ Language _____ Race (optional) _____

Responsible Party Information: (statements will be addressed to the responsible party)

Name _____

Address _____

City, State, Zip _____

Home Phone No. _____ Work Phone No. _____

Date of Birth: _____ Social Security No.: _____

Sex: ☐ Male ☐ Female ☐ OK to leave message

Advance Directive (Living Will):

☐ HAS – has one will bring it at next office visit
☐ INP – in the process of making one
☐ WM – will make one

LAST NAME _____ FIRST NAME _____ DOB_____

Insurance Information: (**Primary Insurance)**

Insurance Name: _____

Address: _____

Phone No.: _____

Subscriber's Name: _____

Subscriber ID No.: _____ Group No.: _____

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Date of Birth :_____Co-Payment Amount: _____

Insurance Information: (Secondary Insurance)

Insurance Name: _____

Address: _____

Phone No.: _____

Subscriber's Name : _____

Subscriber ID No.: _____ Group No. _____

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Date of Birth: _____ Co-Payment Amount :

_____ **Responsible Party's Employer Information:**

Company: _____

Address _____ City _____

State _____ Zip _____ Phone No. _____

Emergency Contact #1

Name: _____
Phone: _____
Address: _____
_____
Relationship: _____

Emergency Contact #2

Name: _____
Phone: _____
Address: _____
_____
Relationship: _____

LAST NAME _____ FIRST NAME _____ DOB_____

HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and/or health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality rights should collection action become necessary. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office. However, we are not obliged to alter internal policies to conform to your request.

My protected health information can be released to the following people:

Name: _____ Relationship: _____ Phone: _____

Address: _____

Name: _____ Relationship: _____ Phone: _____

Address: _____

Name: _____ Relationship: _____ Phone: _____

Address: _____

HIV/AIDS/STD: This form authorizes release of medical information including HIV related. Confidential HIV-related information is any information indicating that a person has had an HIV related test, or has an HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV. **I DO ____ DO NOT ____** consent to the release of any positive or negative test result for AIDS/HIV or STD infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial: _____ Date: _____**

With this consent, I give Bestcare Internal Medicine permission to call my home or other alternative location provided in the patient information form and leave a detailed message on voicemail or in person with someone listed above in reference to the items that assist the Practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as lab and test results. You may revoke this authorization by submitting a written request to our office anytime.

_____ _____

Patient Signature (or parent, guardian or legal representative) **Date**

LAST NAME _____ FIRST NAME _____ DOB_____

HEALTH HISTORY QUESTIONNAIRE

Date of last physical : **Date:**

Your Medical History

- ☐ Hay fever (allergies)
- ☐ Hearing loss
- ☐ Cataracts
- ☐ Other eye diseases _____

LUNGS

- ☐ Asthma
- ☐ COPD
- ☐ Lung nodule
- ☐ Other lung diseases _____

HEART

- ☐ HTN (high BP pressure)
- ☐ Heart attack (MI)
- ☐ Heart Failure
- ☐ Heart arrythmias
- ☐ Atrial Fibrillation
- ☐ High cholesterol or triglycerides
- ☐ Other heart disease _____

GASTRIC

- ☐ Acid Reflux
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ IBS
- ☐ Hepatitis

BONE/MUSCULAR

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Other rheumatoid disorders _____

ENDOCRINE

- ☐ Diabetes
- ☐ PreDiabetes
- ☐ Menopause
- ☐ Polycystic Ovarian Disorder
- ☐ Hypothyroidsm(low thyroid)
- ☐ Other Endocrine disorders _____

KIDNEYS

- ☐ Kidney diease
- ☐ Kidney stones
- ☐ Enlarged Prostate
- ☐ Frequent Urinary infections
- ☐ Other Kidney diseases _____

NEUROLOGICAL

- ☐ Stroke/TIA (ministroke)
- ☐ Migraine Headaches
- ☐ Other headaches
- ☐ Seizures
- ☐ Dementia
- ☐ Parkinson's
- ☐ Other Neurological issues _____

SKIN

- ☐ Skin cancer
- ☐ Eczema
- ☐ Other skin issues

BLOOD

- ☐ Anemia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Blood clot
- ☐ Other blood disorders _____

LAST NAME _____ FIRST NAME _____ DOB_____

HEALTH HISTORY QUESTIONNAIRE

ANY CANCER	**PSYCHIATRIC**	
	☐ Depression	☐ Other Psych issues
_____	☐ Anxiety	_____
	☐ ADD	
_____	☐ Bipolar	_____
	☐ Eating disorders	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

LAST NAME _____ FIRST NAME _____ DOB_____

HEALTH HISTORY QUESTIONNAIRE

Immunizations

Immunization	Date	Immunization	Date
☐ Influenza		☐ Pneumovax	
☐ Shingles (zotavax)		☐ Gardisil	
☐ Hepatitis B		☐ Tetanus	
☐ Hepatitis A		☐ dTap	
☐ MMR		☐ Any other Vaccines	

Screening Male and Female	Date		
☐ Stool Cards		☐ Normal	☐ Abnormal
☐ Colonoscopy		☐ Normal	☐ Abnormal
☐ Bone Density		☐ Normal	☐ Abnormal
Which imaging center: _____			

Screening Male	Date		
☐ PSA		☐ Normal	☐ Abnormal
☐ Testicular Exam		☐ Normal	☐ Abnormal

Screening Female	Date		
☐ Pap Smear		☐ Normal	☐ Abnormal
☐ Mammogram		☐ Normal	☐ Abnormal
Which imaging center: _____			

LAST NAME _____ FIRST NAME _____ DOB_____

HEALTH HISTORY QUESTIONNAIRE

List all your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (BRING ALL BOTTLES)

Name of the Drug	Strength	Frequency Taken

Allergies to medications

Name of the Drug	Reaction you had

Allergies to all other agents including food

Name of agent or food	Reaction you had

LAST NAME _____ FIRST NAME _____ DOB_____

HEALTH HISTORY QUESTIONNAIRE

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used: _____		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Would you like to speak with your provider about your risks of HIV/AIDS	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an advanced directive or living will?	☐ Yes	☐ No
	Would you like information for the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children**		
			☐ Male ☐ Female		
Mother					
			☐ Male ☐ Female		
Siblings					
☐ Male ☐ Female			☐ Male ☐ Female		
☐ Male ☐ Female			☐ Male ☐ Female		
☐ Male ☐ Female			**Maternal**		
			Grandmother		
☐ Male ☐ Female			Grandfather		
			Paternal		
☐ Male ☐ Female			Grandmother		
			Grandfather		

LAST NAME _____ FIRST NAME _____ DOB_____

Bestcare Internal Medicine Practice Policies

Please read each section carefully, initial each section and sign at the bottom.

Prescription Policy

For prescription renewals, contact your pharmacy. The turnaround time is 24 – 48 hours, so please call before you run out of your medication. For your safety, we will refuse to prescribe medications for a new problem without seeing you at the office. Depending on your medical condition we in general require that anyone on continuing medication be seen every 3 months to evaluate drug effectiveness and to detect possible adverse reactions. Prescriptions for medications are given at office appointments. If there are no refills remaining on your prescription, you will need to schedule an appointment before you run out. Before each office visit, review your medication list and make sure that you have enough refills of all your medication to last until your next office visit. **For all refill requests please call your pharmacy to send us a request**. If your pharmacy contacts our office for renewal authorization and no refill has been authorized it is because you need an appointment. **For each visit you MUST bring ALL your medication bottles with you.**_____ ***initials***

Phone Policy

Our office staff can answer general questions. If you need to speak with one of the providers, please inform the front desk of the nature of your call. Except for emergencies, our first priority is to patients in the office, so the message will be reviewed after the provider is done seeing patients. If you feel very ill we advise all of our patients to call 911 or go to the emergency where you can be treated promptly**.** _____ ***initials***

Referral Request Policy

Some insurance plans require a referral to see another physician or a pre-certification to have certain procedures done. In most instances your provider will have to see you before we can provide a referral for you. The nature of the referral needs to be addressed and documented in your chart during a face to face visit**,** please call our office to schedule an appointment if you need a referral or let us know during your office visit. Unless an urgent referral is required, please allow up to **14 days for your referral to be completed.**_____ ***initials***

Results of Diagnostic/Lab Tests Policy

If you have a test performed, please schedule a follow up within 10 days of the test to go over results**. It is your responsibility to call and schedule an appointment to go over all results.** _____ ***initials.***

Copay Policy

Any patient out-of-pocket expense is expected on the date of service. We do except Master Card, Visa, American Express and Discover. **ANY other account balances are also due at the time of service.**_____ ***initials***

LAST NAME _____ FIRST NAME _____ DOB_____

Special Letters & Forms Policy

Employers, insurance companies, and others sometimes ask that we prepare letters or forms containing detailed information about the medical care we provide. There are fees for these forms and some require an appointment. Such forms include, but are not limited to, completing disability forms, health questionnaires, assisted living and composing various letters. The fee varies please call our office to ask what the fee maybe for your request and if it requires an appointment. Completion time varies by form._____ *initials*

Missed Appointments/Late Cancellation Policy

We appreciate your consideration of the provider's schedule. When patients do not show for an appointment it hinders our ability to efficiently manage the schedule and impacts other patients**. We require 24 hour advance notice of cancellation.** A **$50.00** fee will be applied to your account for short-notice cancellations or missed appointments. If you have scheduled a first appointment of the day, you **MUST** come 20 minutes before your appointment. Patients who miss several appointments without calling may be discharged from our practice._____ *initials*

Same Day Appointment Policy

Our office has blocked appointment times so we are able to accommodate our patients with same day urgent appointments. Please call our office before going to an urgent care clinic or the hospital. When using an urgent care clinic or a hospital your out-of-pocket expense will be greater._____ *initials*

Dismissal Policy

If you are "dismissed" from our practice it means you can no longer schedule appointments, get medication refills or consider us your medical provider. *Common reasons for dismissal are failure to keep appointments (frequent no shows), noncompliance, abusive to staff, failure to pay your bill.*_____ *initials*

Lab Fee Policy

There is a $25 lab convenience fee when our office staff draws your blood. For those who cannot afford the time and hassle of waiting at a lab draw station. It is understood that this convenience fee is not for the drawing and handling of you blood and that it is not a "Covered Service" by your insurance company. Therefore, this fee is not reimbursable by you insurance company. _____ *initials*

MANDATORY Annual Exam/Wellness Visit Policy

An annual physical exam visit is mandatory once yearly for all of our patients under the age of 65. The annual wellness visit is mandatory of all patients over the age of 65. Questionnaire for your annual visit is available at www.bestcareaz.com. The annual visit is a designated time to review all problems, medications and ensure that all cancer screening and other preventive measures are up to date. The annual visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment and possibly a copay. Please let our scheduling staffs know if you need the providers help with a health problem, a medication refill or something else. We need to schedule a separate appointment**.**_____ *initials*

LAST NAME _____ FIRST NAME _____ DOB_____

Financial Policy

If you have no Insurance: Payment will be due at the time of service, ask the front desk for cash-pay prices. **If you have insurance:** Although we are contracted with several insurance companies, it is **your** responsibility to make sure that our provider is in your plan and if you are in an HMO plan which requires an assigned primary care provider, make sure this is done before your scheduled appointment**.** *(Please note some plans take longer than others for this change to take effect).* It is also your responsibility to know your insurance benefits.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover). Payments are also accepted by phone and at www.bestcareaz.com

Auto Accident: If your injury is a result of an auto accident, you are required to pay for services and then collect from the auto carrier. We will not file your insurance but will provide you with a receipt to do so.

Liability Injury: If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance but will provide you with a receipt to do so.

Worker's Compensation: If your injury is due to an accident in your work place, please inform the front desk immediately. You will need to contact your supervisor for instructions on how to file a worker's compensation claim. We regret any inconvenience this may cause.

Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact our billing department, if you think there is a problem. If you cannot pay your entire balance, please call to make payment arrangements.

Collections: Accounts that are not paid within 30 days begin our in house collection process. If your balance becomes 90 days old, your provider will be notified and you may be subject to dismissal from the practice. _____ ***initials***

Please note all of these polices have been created for your own safety, health and well-being as well as requirements by health insurance plans. We thank you for your cooperation and choosing Bestcare Internal Medicine as your medical provider. A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST, PLEASE INFORM FRONT DESK.

PATIENT SIGNATURE: _____

NAME: _____ **DOB:** _____

SUMMARY PRIVACY PRACTICES

As a patient of Bestcare Internal Medicine, we want to inform you of an important protection for patient privacy that is effective as of April 14, 2003. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 permits the federal government to give practices, such as ours, specific rules about the storage and transmission of personal health care information. The Privacy Rule portion of the Act tells us how to use "individually identifiable health information" (IIHI) about patients within our practice and how to disclose it outside our practice.

HIPAA requires that we adopt a Notice of Privacy Practices and provide you a copy. This is a lengthy Notice, so to make it easier for you to understand, we have listed the patient rights that are detailed in the attached Notice of Privacy Practices:

- Patients have the right to receive copies of our Notice Privacy Practices
- Patients can give permission to the practice to use and disclose IIHI for certain purposes and for psychotherapy notes
- Patients can ask for restrictions on certain uses and disclosures of IIHI
- Patients can ask for restrictions on the way(s) in which we communicate IIHI to them
- Patients can ask us to change the IIHI that is contained in their medical records
- Patients can ask to inspect and copy IIHI
- Patients can ask for a list of disclosures of IIHI made by the practice
- Patients have the right to complain to our practice and to the department of Health and Human Services about alleged violations of the Privacy Practice

We fully support HIPAA and the Privacy Rule. As our patient, we ask you to sign the following Receipt Acknowledgement of our Notice of Privacy Practices, and we will be glad to provide you with a personal copy of the complete Notice if you would like to have it for your records.

Receipt Acknowledgement of Notice of Privacy Practices

I, _____, have received a copy of Bestcare Internal Medicine,
Patient Name
Notice of Privacy Practices. www.bestcareaz.com/privacypractices

_____ _____
PATIENT SIGNATURE **Date**

LAST NAME _____ FIRST NAME _____ DOB_____

PATIENT CONSENT FORM

I consent to the use or disclosure of my protected health information by BESTCARE INTERNAL MEDICINE, PLLC for the purpose of my diagnosis, treatment, payment, or to conduct health care operations.

I understand the following:

- Diagnosis or treatment of me by BESTCARE INTERNAL MEDICINE staff providers may be conditioned upon my consent as evidenced by my signature on this consent.
- I have the right to request a restriction on the uses of my protected health information; the physician's practice may not agree with the restrictions. However, if they do agree, the restriction is binding.
- I have the right to revoke this Consent, in writing, at any time; all future disclosures will subsequently cease. Any disclosures previously made from my prior consent, will not be affected by this revocation.
- Prior to signing this consent, I have the right to review Bestcare Internal Medicine, PLLC Notice of Privacy Practices & Financial Policy, which have been provided to me.

My "protected health information" means health information, including my demographics information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Bestcare Internal Medicine, PLLC has a Notice of Privacy Practices. The Notice of Privacy Practices describes how we may use and disclose protected health information about you. The Notice of Privacy Practices also describes patient rights under the law.

Bestcare Internal Medicine, PLLC may change the privacy practices as described in the Notice of Privacy Practices. I may contact the office to receive a revised copy.

This document is provided in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a courtesy to our patients, we will file up to 2 insurance companies. Because we are Medicare Providers, we must first file to the insurance companies of all Medicare patients.

Medical Information Release-Direct Physician Payment Release

By Signing below, I authorize the release of all medical information necessary for filing my insurance claims. I also authorize my insurance company to make direct payment to my physician. A copy of this release may be used in place of the original. I understand that I am responsible for any balance due on my account after my insurance carriers(s) have paid, including my yearly deductibles, co-payments and coinsurance. I also understand that any overpayment will be refunded if authorized by my insurance company.

Patient Signature _____ Date _____

Parent/Legally Authorized Representative _____ Relationship to Patient _____

BESTCARE INTERNAL MEDICINE, PLLC
13945 W. GRAND AVE SUITE A-105
SURPRISE, AZ 85374
T. 623.546.0007 F. 623.584.6915

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE (HOME) _____ **(WORK)** _____

I hereby authorize *(PROVIDE PROVIDER NAME AND FAX, WE CANNOT SEND A REQUEST WITHOUT THIS INFORMATION)*

Provider Name: _____

Fax No. (REQUIRED) _____

to send/release photocopies of my medical records to:

BESTCARE INTERNAL MEDICINE, PLLC
13945 W. GRAND AVE SUITE A-105
SURPRISE, AZ 85374

Phone: (623) 546-0007 Fax : (623) 584–6915

I authorize the release of photocopies of the following records in the possession or control of its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S SECTION 36-611), CONFIDENTIAL ALCHOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

REQUESTED THE FOLLOWING ONLY. DO NOT SEND ALL MEDICAL RECORDS

Progress Notes (1 year)	Laboratory Reports (1year)
Colonoscopy/Mammogram/Dexa/EKG	Imaging Studies (3 years)
Consultation Reports (1 year)	Vaccinations

Other: _____

This consent will expire one (1) year after the signed date below. I have given my consent freely and voluntarily. I may revoke this authorization at any time provided I notify my PCP in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Legally Authorized Representative **Relationship to Patient**