CONCIERGE
Internal Medicine Associates

NEW PATIENT INFORMATION

Date: _____ Contact Preference: ☐Home ☐Mobile ☐Text ☐E-mail

Patient's Name: _____

SS# _____ Sex: _____ Age: _____ Date of Birth: _____

Marital Status: S M W D Home Telephone Number: _____

Local Address: Mobile Number: _____

_____

_____

E-Mail Address: _____

**(by giving us your email address, you are signing up for our patient portal, a website that is used to view lab results, request appointments and prescription refills and communicate with the doctor.)

Out of State Address: _____

_____

Patient's Employer: _____

Pharmacy: _____

Are you a seasonal resident? ◯ Yes ◯ No

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____

Telephone: _____ Relationship: _____

Is this person Power of Attorney and/or Health Care Surrogate? Yes◯ No◯

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INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE: _____

ID#: _____ GROUP#: _____

SECONDARY INSURANCE: _____

ID#:_____ GROUP#: _____

AUTHRORIZATION TO SHARE MEDICAL INFORMATION:

I authorize Concierge Internal Medicine to use and disclose a copy of health and medical information to the following:

Name of Person Authorized to Receive Information: _____

Phone: _____ Additional Phone: _____

☐ No Expiration Date

☐ Expiration Date

☐ I authorize Concierge Internal Medicine to leave messages on my voicemail/answering machine such as test results and/or message that may contain personal information.

AUTHORIZATION TO BILL AND RELEASE MEDICAL INFORMATION

I authorize the submission of claims(s) for payment to Medicare, Medicaid or any other payor for any services provided to me by Concierge Internal Medicine. I authorize the release of any information acquired during my treatment to my insurance company. I understand that I am financially responsible for the services and supplies provided to me by Concierge Internal Medicine regardless of my insurance coverage and, in some cases, may be responsible for an amount in addition to that which was paid by my insurance (i.e. copays and deductibles). I request that payment of authorized benefits be made either to me or on my behalf for any services received. I agree to immediately remit to Concierge Internal Medicine any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Concierge Internal Medicine. I authorize Concierge Internal Medicine to appeal payment denials or other adverse decisions on my behalf. I authorize any holder of medical information or other relevant information about me to release such information to Concierge Internal Medicine, its billing agents, the Center of Medicare and Medicaid Services and/or any other payors or insurers and their respective agents or contractors as may be necessary to determine benefits payable for any services provided to me by House Call Specialists.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Daniel L. Boss, M.D.

MEDICAL HISTORY:

Known Allergies (including reactions): _____

PAST MEDICAL ILLNESSES:

- ☐ **HYPERTENSION**
- ☐ **DIABETES MELLITUS**
- ☐ **HEART DISEASE**
- ☐ **HEPATITIS**
- ☐ **RESPIRATORY DISEASE**
- ☐ **ATRIAL FIBRILLATION**
- ☐ **THYROID DISEASE**
- ☐ **EMPHYSEMA (COPD)**
- ☐ **STROKE**
- ☐ **PEPTIC ULCER DISEASE**
- ☐ **ANXIETY**
- ☐ **TUBERCULOSIS**
- ☐ **KIDNEY DISEASE**
- ☐ **LIVER DISEASE**
- ☐ **PHLEBITIS**
- ☐ **HEART MURMUR**
- ☐ **HIV/AIDS**
- ☐ **CANCER: TYPE AND WHEN DIGNOSED?**

OTHER; PLEASE SPECIFY: _____

MEDICATIONS AND MILLIGRAMS:_____

_____

SURGICAL HISTORY:

_____

_____

SOCIAL HISTORY:

Do you have regular exercise habits? ☐ Yes ☐ No

Do you sleep regularly? ☐ Yes ☐ No

Do you eat well balanced meals? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How long? _____ How much? _____

Have you ever smoked? ☐ Yes ☐ No When did you quit? _____

Do you drink? ☐ Yes ☐ No How much per week? _____

FAMILY HISTORY:

Mother living? ☐ Yes ☐ No Died at age: _____ Cause: _____

Father living? ☐ Yes ☐ No Died at age: _____ Cause: _____

Brothers living? ☐ Yes ☐ No Died at age: _____ Cause: _____

Sister living? ☐ Yes ☐ No Died at age: _____ Cause: _____

Does anyone in your immediate have heart disease, diabetes, cancer or any other chronic illness?

_____

_____

HEALTH MAINTENANCE:

Do you take Aspirin? ☐ Yes ☐ No

Have you had a colonoscopy? ☐ Yes ☐ No When? _____

Have you had a pneumonia vaccine? ☐ Yes ☐ No When? _____

Have you had a mammogram? ☐ Yes ☐ No When? _____

Have you had a breast exam: ☐ Yes ☐ No When? _____

Date of last gynecological exam? _____

Date of last digital rectal exam? _____

Have you had a PSA (if male)? ☐ Yes ☐ No When? _____

****When form is completed, bring with you to your appointment or fax (561) 629-5560.**

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AUTHORIZATIONS:

I,_____ acknowledge that I received a copy of the Notice of (Patient Name Printed) Privacy Practices of Concierge Internal Medicine ("Practice").

By signing this form, I acknowledge that the Practice has provided me with its Notice of Privacy Practices which explains how my health information may be handled in various situations including treatment, healthcare operations, payment and administration of plans. If my first date of service was due to an emergency, the practice will try to provide me with its Notice and obtain my written acknowledgement for the Notice as soon as possible once the emergency has passed. My signature also authorizes the Practice to use or disclose my health information for research and other purposes, as described in the Notice.

Signature: _____ Date: _____

Print Name: _____

PATIENT REPRESENTATIVE (If Patient unable to sign)

Name Printed: _____ Signature: _____

Relationship to Patient: _____ Date: _____

For Office Use Only:

Complete if Acknowledgement of Receipt of Notice of Privacy Practices is not obtained.

I personally delivered the Notice of Privacy Practices to the patient/client listed above and made a good faith effort to obtain this written Acknowledgement.

The reason that a written Acknowledgement of receipt of the Notice by the patient/client was not obtained was due to:

_____

Name Printed: _____ Signature: _____

Daniel L. Boss, M.D.

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ADVANCE PATIENT NOTICE FORM

You have the right to receive services at a participating facility or by a participating physician or provider in order to obtain full benefits under your health coverage. If you have questions or would like to locate an in-network physician, provider or facility, please contact your customer service provider on the back of your insurance card.

To be completed by the patient or patient's legal guardian:

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that the non-participating facility/provider that will be involved in my care does not participate with my insurance company.
2. I understand that I will be responsible for all costs for all services provided by the non-participating facility/provider.
3. I was given an opportunity to contact my insurance company before obtaining these services to confirm my benefits for these non-network services and to obtain names of participating facilities and/or providers that can provide the recommended service or procedure.
4. I am voluntarily choosing on behalf of myself, or my adult child/legal guardian to obtain the service or procedure from the non-participating facility and/or physician.

_____ _____

Patient Signature: Date:

Concierge Internal Medicine

HIPAA NOTICE OF PRIVACY PRACTICES As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility.

We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 561-972-1986 or email info@conciergeinternalmedicine.com.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Daniel L. Boss, M.D.

Submit