Office of Paul H. Deutsch M.D., R.Ph., LLC

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RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

New Patient Registration Form

Welcome to our practice. Please print all information.

SECTION 1: PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security #:_____ DOB:_____Gender: M / F

Marital Status: ◯ Married ◯ Single ◯Widowed ◯ Divorced ◯ Legally Separated

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different than above): _____

Primary Phone #: _____ Alternate Phone #:_____

Previous or Referring Provider: _____

SECTION 2: GUARANTOR INFORMATION /RESPONSIBLE PARTY *(If different from the patient)*

Guarantor's Name: _____Relationship to patient: _____

Date of Birth: _____Phone #: _____Social Security #: _____

SECTION 3: EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Emergency Contact Address: _____

Emergency Contact Phone: _____ Relationship _____

Race: ◯ Asian ◯ African American ◯ Hispanic ◯ American Indian or Alaska Native

◯ Native of Hawaii/Pacific Islander ◯ White ◯ Other (Please specify):_____

Ethnicity: ◯ English ◯ Spanish ◯ French ◯ Dutch ◯ Chinese ◯ Greek ◯ Hindi ◯ Russian

◯ Portuguese ◯ German ◯ Other (Please specify):_____

Email Address: _____

SECTION 4: EMPLOYMENT

Employment Status: ◯ Full Time ◯ Part Time ◯ Not Employed ◯ Retired ◯ Active Military ◯ Full-time Student ◯ Part-time Student

Employer: _____Phone Number: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORK OR AUTO RELATED INJURY? YES / NO / UNDETERMINED
If yes or undetermined, please ask receptionist for addition paperwork.

SECTION 5: SUBSCRIBER INFORMATION *Please present insurance card(s) to receptionist for copying.*

PRIMARY *(Self/Significant Other /Parent or Guardian)*	**SECONDARY** *(Self /Significant Other /Parent or Guardian)*
Insurance Name: _____	Insurance Name: _____
Effective Date: _____	Effective Date: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Subscriber S.S. #:_____	Subscriber S.S. #:_____
I.D. #/Policy #: _____	I.D. #/Policy #: _____
Group/Plan #: _____	Group/Plan #: _____

If Medicare is secondary, circle reason: *Working Spouse has insurance Veteran Disabled*

Other: _____

SECTION 6: AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I have been provided a copy of the Paul H. Deutsch M.D., R.Ph., LLC Financial Policy. I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements promptly upon their presentation unless credit arrangements are agreed upon in writing.

I authorize payment of insurance benefits be made directly to Paul H. Deutsch M.D., R.Ph., LLC for services rendered. I authorize Paul H. Deutsch M.D., R.Ph., LLC to release any medical information necessary to process claims for payment.

I acknowledge I have received Paul H. Deutsch M.D. R.Ph., LLC Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information and how I can access this information. I understand I am entitled to receive updates upon request if Paul H. Deutsch M.D., R.Ph., LLC Notice of Privacy Practices is amended or changed in a material way. I also understand if I have question or complains I may contact the Privacy Officer at 860-889-0025.

Patient/Guarantor Signature _____ Date: _____
This authorization will remain in effect unless rescinded in writing by the above signed.

Clinical Information

Welcome to our practice. Please print all information.

Patient Name: DOB:

Primary Pharmacy: _____City:_____

Childhood Illness:	¨ Measles ¨ Mumps ¨ Rubella ¨ Chickenpox ¨ Rheumatic Fever ¨ Polio	
Immunizations and dates:	¨ Tetanus	¨ Pneumonia
	¨ Hepatitis	¨ Chickenpox
	¨ Influenza	¨ MMR *Measles, Mumps, Rubella*

List your prescribed drugs and over-the-counter drugs, such as vitamins and supplements

Name the Drug	Strength	Frequency Taken

Medical History: Please list conditions and date diagnosed

Medication Allergies

Drug Name	Reaction You Had

Patient Name: DOB:

Surgeries: Have you ever had any of the following?

Screening Procedures	*Date*	*Location/Result*
Colonoscopy:		
Mammogram:		
Pap Smear:		
Bone Density:		
Other:		
Other:		

Other Surgeries:	*Date*	*Location*

Other hospitalizations: Please Do Not Include Hospitalizations for Outpatient Surgeries

Year	*Reason*	*Hospital*

Family History

Family Member	Alive	Deceased	Age	Conditions:
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Siblings				
Children				
Other Family History				

How many siblings do you have? (please indicate brothers and sisters separately)

How many children do you have? (please indicate sons and daughters separately)

Patient Name: DOB:

Social History

Do you use tobacco?	Y / N	If yes, what form and how much?	
How long have you used tobacco?	yrs.		
		If no, did you ever quit?	
		When did you quit?	
Do you drink alcohol?	Y / N	If yes, how many drinks in 1 week?	
Do you drink caffeine?	Y / N	If yes, how many 12oz servings/day?	
Do you use recreational drugs?	Y / N		
Do you exercise?	Y / N	How often per week?	
Do you have frequent falls?	Y / N		
Do you have a history of depression?	Y / N	Do you see a psychiatrist/psychologist?	
Do you have vision loss?	Y / N	Do you wear glasses or contacts?	Y / N
Do you have hearing loss?	Y / N	Do you wear hearing aids?	Y / N
Have you traveled outside of the U.S?	Y / N	Countries:	
What do you do for work?			
Occupational Exposure?			

Domestic Abuse

Who do you live with?					
Do you feel safe in your home?				Y / N	Please explain all no answers:

Sex: If Applicable

Are you sexually active?			Y / N	
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				Y / N

I agree to comply with urine testing to document proper use of medication

_____ _____

Patient Signature *Date*

Are you experiencing any of the following symptoms?					
Y / N	**CONSTITUTIONAL**	**Y / N**	**BREAST**	**Y / N**	**MUSCULOSKELETAL**
	Fatigue		Discharge from nipple		Neck Stiffness
	Weight loss		Breast tenderness		Neck pain
	Weight gain		Breast mass		Back stiffness
	Fever				Back pain
	Chills	**Y / N**	**GASTROINTESTINAL**		Joint swelling
Y / N	**EYES**		Loss of appetite		Joint pain
	Double vision		Trouble eating		Limitation of joint movement
	Blurred vision		Abdominal pain		Muscle pain
	Sensitivity to light		Nausea	**Y / N**	**SKIN**
	Reduced vision		Vomiting		Skin rash/ lesions
	Eye redness		Change in bowel habits		Dry itchy skin
	Eye itching		Diarrhea		Nail problems
	Eye pain		Constipation		
			Blood in stool	**Y / N**	**NEUROLOGIC**
Y / N	**EARS**	**Y / N**	**GENITAL / URINARY**		Headache
	Ear discharge		Pain with urination		Dizziness
	Ear pain		Blood in urine		Lightheadedness
	Tinnitis		Discharge		Fainting
	Hearing loss		Dribbling of urine		Weakness
Y / N	**NOSE / THROAT**		Frequent urinating at night		Numbness/Tingling
	Nasal congestion		Testicular mass		Tremor
	Nasal discharge		Testicular pain		
	Postnasal drip		Problems with erections	**Y / N**	**PSYCHIATRIC**
	Sneezing	**Y / N**	**HEMATOLOGIC LYMPHATIC**		Difficulty sleeping
	Runny nose		Swollen glands		Mood Swings
	Sore throat		Lymph node tenderness		Feeling Anxious
	Bleeding gums		Anemia		Feeling Depressed
	Hoarseness		Bruise easily		Confusion
Y / N	**RESPIRATORY**		Bleed easily		Memory Loss
	Shortness of breath			**Y / N**	**ENDOCRINE**
	Cough				Frequent hunger
	Wheezing				Drinking a lot
	Pain with breathing				Frequent urination
Y / N	**CARDIOVASCULAR**				Enlarged thyroid
	Chest pain				Intolerant of heat
	Palpitations				Intolerant of cold
	Irregular heart beat				

Please explain all yes answers:

Office of Paul H. Deutsch M.D. R.Ph., LLC

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss then with our Patient Financial Counselor. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept check, cash, Visa, Discover, Amex or MasterCard.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- Your assistance in securing timely payments of you claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary physician or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.
- Each month you will receive a monthly statement for services which is due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- Not all services are a covered benefit in all insurance plans. Some health plans select certain services that they will not cover. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment of balance that is designated as the patient's responsibility is due upon receipt of a statement from our office.
- We will bill your health plan for all service provided in the office or hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- There is a fee of $25.00 assessed for non-sufficient funds in addition to the fee from your financial institution.
- Keep in Touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In the event my account is referred to an attorney or collection agency for collection I agree to pay for processing or convenience fees if required as a cost of collection of my account. I understand that such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Please Print the name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

Office of Paul H. Deutsch M.D., R.Ph., LLC

HIPAA PRIVACY NOTIFICATION / DISCLOSURE TO FAMILY AND FRIENDS

_____

First Name Last Name Middle Initial

Primary Phone: _____ Date Of Birth: _____

We may need to contact you by phone about results, appointments, or referrals. You may request the list of people involved with your care be expanded or restricted. You have the right to amend this information at any time. To facilitate contacting you in a timely manner and to comply with federal HIPAA regulations, please complete the information below.

_____ You may only speak to me personally.

_____ You may call me at work. Work Phone: _____ Ext. _____

_____ You may call my cell phone. Cell Phone: _____ Text: YES / NO

_____ You may leave a message on my answering machine or voice mail regarding those items checked below at:

_____ Home _____ Work _____ Cell

_____ You may leave a message with the following members:

___ Spouse/Name: _____Phone: _____

___ Children/Name: _____Phone: _____

___ Parent/Name: _____ Phone: _____

___ Other/Name: _____Phone: _____

RX HISTORY CONSENT

- *By signing below, I agree to allow Paul H. Deutsch M.D., R.Ph., LLC to review any prescription history available to my electronic health record.*

FINANCIAL

- *In the event my account is referred to an attorney or collection agency for collections I agree to pay for processing or convenience fees if required as a cost of collection of my account. I understand that such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.*

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to Paul H. Deutsch M.D., R.Ph., LLC.

I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

PRIVACY PRACTICES (HIPAA)

- *By signing below I acknowledge that I was provided with the Notice of Privacy Practices.*

I understand that Paul H. Deutsch M.D., R.Ph., LLC will make reasonable efforts to accommodate this request for as long as I am a patient; but I can request a change at any time. I further understand that in some emergency situations, my protected health information may be released.

_____ _____

Patient/ Parent/ Guardian Signature Date

Office of Paul H. Deutsch M.D. R.Ph., LLC

Secure Messaging

Paul H. Deutsch MD RPh LLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Print Sign Date