STANISLAW P. CHORZEPA, D.O.
211 New Britain Road, Suite 103
Kensington, CT 06037
Phone: (860) 890-0300
Fax: (860) 893-0301
Email: administrator@drchorzepa.com

Dear New Patient,

Welcome to our practice! Thank you for allowing us to serve your medical needs. The following information is provided to ensure a smooth transition into our practice.

Please complete the forms and either email them to our office or bring them with you to your first appointment, it will help speed up the check in process.

If you have medical insurance, please bring all of your current insurance and valid photo identification cards with you at the time of your appointment. Please check to make sure that your cards are not expired. This will help complete your chart.

Plan on bringing any required copayments to your office visit and it will be collected at the time of check in. For self-pay patients, payment in full at the time of service is required. We accept cash, checks, and all major credit cards.

Thank you! We look forward to meeting you soon.

Sincerely,

Stan P. Chorzepa D.O.

Dr. Stanislaw P. Chorzepa & Staff

FORMA DEMOGRAFICZNA PACJENTA

Prosimy o wydrukowanie. Wszystkie informacje będą poufne.

NAZWA:_____**Data urodzenia**:_____/____/_____
Nazwisko Imię Drugie imię

ADRES:_____
Ulica Miasto Stan Kod pocztowy

PŁEĆ: ☐ Mężczyzna ☐ Kobieta ☐ Wolę nie ujawniać **SOCJAL NUMER:** _____-_____-_____

Rasa	**Pochodzenie**	**Preferowany język**	**Palenie Tytoniu**
☐ Biały	☐ Nie-Hiszpańskie	☐ Angielski	☐ Nigdy nie paliłem/łam
☐ Czarny	☐ Hiszpańskie	☐ Polski	☐ Rzuciłem/łam palenie
☐ Azjatyckie		☐ Hiszpańskie	☐ Palę okazjonalnie
☐ Inne:_____		☐ Inne:_____	☐ Obecnie palący codziennie

Stan cywilny: ☐ żonaty/zamężna ☐ kawaler/panna ☐ w separacji ☐ wdowa ☐ rozwiedziony/a ☐ partner/ka

Preferowana apteka: Nazwa _____ Miejscowość_____

NUMER TELEFONU

Domowy:_____ Czy możemy zostawić wiadomość na ten numer? ☐ Tak ☐ Nie

Komórka:_____ Czy możemy zostawić wiadomość na ten numer? ☐ Tak ☐ Nie

Praca:_____ **Adres e-mail:**_____

Czy chcesz przypomnienia o wizytach przez ☐E-MAIL ☐TELEFON ? (jeśli telefon: dom/komórka/praca)
kółko jeden

Nazwa pracodawcy: _____

Adres pracodawcy:_____

INFORMACJE UBEZPIECZENIOWE

Podstawowe Ubezpieczenie:_____	**Drugie** Ubezpieczyciel:_____
Imię i nazwisko subskrybenta:_____	Imię i nazwisko subskrybenta:_____
Powiązanie z subskrybentem: ☐własny ☐małżonek/ka ☐zależny/a	Powiązanie z subskrybentem: ☐własny ☐małżonek/ka ☐zależny/a
Polisa#_____	Polisa#_____
Grupa#_____	Grupa#_____

KONTAKT AWARYJNY

(jeśli nie możemy się z tobą skontaktować)

Imię:_____ Związek:_____ Numer telefonu:_____

☐ SPRAWDŹ TUTAJ, CZY WIZYTA JEST ZWIĄZANA Z **WYPADKIEM SAMOCHODOWYM** LUB **ODSZKODOWANIE PRACOWNIKA.** NUMER ROSZCZENIA:_____

Upoważniam Dr. Stanisława P. Chorzepę do udostępnienia mojej dokumentacji medycznej, daty lub informacji wymaganych przez mojego ubezpieczyciela medycznego w celu rozpatrzenia moich roszczeń medycznych.

Podpis:_____**Data:**_____

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Imię pacjenta:_____ **Data urodzenia:**_____/_____/_____

Ustawa o ubezpieczeniu zdrowotnym oraz o przenośności i odpowiedzialności wymaga, aby biuro zażądało od pacjenta pisemnej, udokumentowanej zgody na omawianie informacji zdrowotnych z rodziną lub przyjaciółmi zaangażowanymi w opiekę nad pacjentem. Może to obejmować informacje o twoim zdrowiu, uzupełnieniach recept, płatnościach i rozliczeniach i tym podobne. Niniejsze upoważnienie obowiązuje do momentu jego cofnięcia przez ciebie. Od czasu do czasu możemy poprosić o jego aktualizację, jednak o ile wymienione poniżej osoby znajdują się w aktach i nie zostaną przez ciebie odwołane, twój podpis pozwala nam udostępniać informacje osobom poniżej. Jeśli jesteś ubezwłasnowolniony lub z innego powodu niezdolny do podjęcia decyzji w tej sprawie, twoje pełnomocnictwo może wprowadzić zmiany w tym dokumencie.

Proszę wymienić WSZYSTKICH członków rodziny lub przyjaciół, z którymi POZWALASZ rozmawiać z tym biurem. Zgodnie z polityką naszego biura nikt nie wymieniony nie będzie miał dostępu do twoich informacji.

_____ _____
Imię osoby/powiązania z tobą Numer telefonu osoby

_____ _____
Imię osoby/powiązania z tobą Numer telefonu osoby

_____ _____
Imię osoby/powiązania z tobą Numer telefonu osoby

Jeśli jest ktoś konkretny, NIE pozwalasz nam porozmawiaj o sobie, podaj imię i nazwisko tej osoby tutaj:_____

PODPIS

_____ _____
Podpis pacjenta/Opiekuna **Data**

Jeśli chcesz, aby wymieniono więcej niż 3 osoby, poproś o drugi formularz. Jeśli ten formularz nie jest podpisany w naszym biurze, musi być poświadczony przez osobę niezwiązaną z tobą.

Proszę podpisać poniżej (TYLKO w przypadku wypełnienia poza biurem)

_____ _____
Podpis powiązanego świadka, **jeśli nie jest w biurze** Data

_____ _____
Imię i nazwisko świadka (wydrukowane), **jeśli nie jest w biurze** Numer telefonu świadka

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize the below mentioned to disclose or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name:_____ **Birth date:**____/____/_____ **Phone:**_____

Social Security #:_____

Information may be ☐ **Disclosed *to* Below Facility** ☐ **Obtained *from* Below Facility**	**Information may be** ☐ **Disclosed *to* Below Facility** ☐ **Obtained *from* Below Facility**
Name/Facility:_____ Mailing Address:_____ City/State/Zip:_____ Phone #: (_____)_____ Fax #: (_____)_____ ☐ Hand/Carry ☐ Mail ☐ Fax	Stanislaw Chorzepa,D.O. 211 New Britain Road, Suite 103 Kensington, CT 06037 Tel. (860) 893-0300 Fax. (860) 893-0301 Email: administrator@drchorzepa.com
The purpose of this disclosure or use is for the following reason: ☐ Transfer of Care ☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ At the request of the patient or legal representative ☐ Other (please specify) _____ **Dates of service of information to be used or disclosed:** _____	**Requested Information:** ☐ **Complete Record** ☐ History & Physical ☐ Laboratory Report ☐ Discharge Summary ☐ EKG Report ☐ Operative Reports ☐ X-Ray Report ☐ Consultations ☐ Billing Statement ☐ Other:_____

I understand that my treatment or continued treatment by _____ is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.

This authorization will be valid for a period of one year from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying _____ in writing, but if I do it will not have any effect on actions that the release took before it received the cancellation.

Copy Fees: I understand that _____ may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut Statute at $0.65 cents per page.

_____ _____ _____

Signature of Patient or Legal Representative **Date** **Printed Name**

If not patient, state the relationship to patient below (legal documentation required as applicable):
☐ *Parent* ☐ *Guardian* ☐ *Conservator* ☐ *Executor of Estate* ☐ *Power of Attorney* ☐ *Other:*_____

NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose.

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Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Summary Notice of Privacy practices and that I may request a full copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Assignment of Insurance Benefit

I hereby authorize direct payment of surgical/medical benefits to Dr. Chorzepa for services rendered to me by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I understand that copay is due at time of visit. I understand that I am responsible for obtaining a referral or pre-certification as required by my insurance, and for any fees incurred as a result of failure to obtain necessary insurance authorization.

Consent to Treat

I hereby give my consent to Dr. Chorzepa and other clinical personnel supervised by Dr. Chorzepa for the evaluation and treatment of the conditions with which I present myself to this office. I hereby authorize the office of Dr. Chorzepa to release any medical information required to permit payment directly to them for services rendered. I authorize Dr. Chorzepa to release information related to my condition to the applicable worker's compensation carrier, my employer, auto insurance carrier, or my personal health insurance carriers as necessary based on the top and place of injury. I recognize and accept the responsibility for the services rendered regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payment, deductible and non-covered services. Dr. Chorzepa will not accept any attorney's letter of protection. Charges are ultimately my responsibility to pay in full, within 60 days of services rendered.

_____ _____

Patient Signature **Date**

E-MAIL AND TEXT MESSAGE CONSENT FORM

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Dla ułatwienia naszym pacjentom nasz gabinet pragnie zaoferować możliwość przekazywania informacji zdrowotnych za pośrednictwem poczty elektronicznej i sms-ów. Podpisując się poniżej, Twój dostawca może udostępniać Ci informacje dotyczące płatności i zdrowia za pośrednictwem wiadomości e-mail i wiadomości tekstowych, dotyczące rozliczeń, diagnozy, leczenia, wyników badań laboratoryjnych i raportów radiologicznych.

Wiem, że nie mam obowiązku upoważnienia gabinetu Dr. Stanisława P. Chorzepa do wysyłania mi e-maili lub smsów. Rozumiem, że e-maile i SMS-y nie są bezpiecznym formatem komunikacji. Istnieje pewne ryzyko, że indywidualne informacje zdrowotne lub inne wrażliwe i poufne informacje zawarte w takiej wiadomości e-mail lub wiadomości tekstowej mogą zostać niewłaściwie skierowane, ujawnione lub przechwycone przez nieupoważnione osoby trzecie. Informacje zawarte w wiadomościach e-mail lub SMS-ach mogą obejmować imię i nazwisko, datę / godzinę wizyt, nazwisko lekarza i numer telefonu lekarza lub inne istotne informacje.

- Pracodawcy i serwisy internetowe mają prawo dostępu i archiwizacji wiadomości e-mail lub smsów przesyłanych przez ich systemy. Jeśli Twój adres e-mail jest adresem rodzinnym, inni członkowie rodziny mogą zobaczyć Twoje wiadomości, dlatego pamiętaj, że wysyłasz e-mail na własne ryzyko. Ze względu na wiele czynników związanych z internetem i pocztą elektroniczną, na które nie mamy wpływu, nie możemy odpowiadać za źle zaadresowane, źle dostarczone lub przerwane wiadomości e-mail. Twój lekarz nie ponosi odpowiedzialności za naruszenia poufności spowodowane przez Ciebie lub osobę trzecią.

- E-maile i SMS-y najlepiej nadają się do rutynowych spraw i prostych pytań. Nie należy wysyłać nam e-maili ani wiadomości tekstowych w nagłych sytuacjach lub w sprawach wymagających natychmiastowej reakcji. Personel biurowy podejmie próbę przeczytania i niezwłocznego odpowiadania na e-maile lub wiadomości tekstowe, ale nie może zagwarantować, że jakakolwiek konkretna wiadomość e-mail lub wiadomość tekstowa zostanie przeczytana i udzielona odpowiedzi w określonym czasie. Kwestie wrażliwe na czas, należy załatwiać telefonicznie.

- Jeśli Twój e-mail wymaga odpowiedzi lub prosi o odpowiedź, a nie otrzymałeś odpowiedzi w rozsądnym terminie, Twoim obowiązkiem jest skontaktowanie się bezpośrednio z biurem Dr. Stanisława Chorzepa.

- Należy dokładnie rozważyć wykorzystanie poczty elektronicznej do przekazywania wrażliwych informacji medycznych, takich jak między innymi; informacje dotyczące chorób przenoszonych drogą płciową, AIDS / HIV, zdrowia psychicznego, niepełnosprawności rozwojowej lub nadużywania substancji odurzających.

- E-maile i wiadomości tekstowe między Tobą a Twoim lekarzem dotyczące diagnozy lub leczenia mogą być drukowane i stanowić część stałych informacji o Twoim stanie zdrowia.

- Twoje e-maile lub wiadomości tekstowe nie będą przekazywane do innych pracowników służby zdrowia spoza Dr. Chorzepa bez Twojej zgody.

- Aby zapobiec wprowadzeniu wirusów komputerowych do naszego systemu, nie wysyłaj do nas załączników w wiadomości e-mail.

- Jesteś odpowiedzialny za ochronę swojego hasła lub innych środków dostępu do poczty e-mail.

Zezwolenie na e-maile i smsy dotyczące ogólnych informacji biurowych, takich jak przypomnienia o wizytach i prośby o wypełnienie ankiet, jest udzielane przez podanie adresu e-mail i numeru telefonu komórkowego w rocznym formularzu demograficznym dostarczonym podczas pierwszej wizyty w danym roku.

Podpisując niniejszy formularz, potwierdzam, że przeczytałem i w pełni rozumiem niniejszy formularz zgody. Wskazuję, że jestem głównym użytkownikiem podanego numeru telefonu komórkowego. Rozumiem zagrożenia związane z przesyłaniem e-maili i smsów pomiędzy gabinetem Dr. Stanisława P. Chorzepa a mną, i wyrażam zgodę na warunki określone w niniejszym dokumencie, a także wszelkie inne instrukcje, z którymi gabinet Dr. Chorzepa może mieć. Odpowiedzi na wszelkie pytania, były odpowiedziane.

Wybierz opcję i podpisz poniżej:

☐ **ZEZWALAM** NA E-MAIL **I** WIADOMOŚCI SMS ☐ **NIE ZEZWALAM** NA E-MAIL ANI WIADOMOŚĆ SMS

Zaznaczając opcję **ZEZWÓL**, rozumiem ryzyko związane z e-mailami i SMS-ami i robię to, wyrażając zgodę do gabinetu Dr. Stanisława P. Chorzepa na przesyłanie mi osobistych informacji zdrowotnych za pośrednictwem poczty elektronicznej i sms-a.

Zaznaczając opcję **NIE ZEZWALAJ**, nie chcę otrzymywać osobistych informacji zdrowotnych za pośrednictwem poczty elektronicznej lub wiadomości tekstowej, a jedynie drogą pocztową.

Podpis Pacjenta/Opiekuna	**Data**	**Imię i nazwisko drukowane**

Proszę wyraźnie podać JEDEN adres e-mail	**Numer telefonu komórkowego**

Office of Stanislaw P. Chorzepa, D.O.

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing **Dr. Chorzepa** as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, co-payments, and patient billing. By signing below and/or by receiving medical services from **Dr. Stanislaw Chorzepa** you agree:

1. You acknowledge and agree to the FINANCIAL POLICIES . You may request a copy from the Staff. These policies may be changed from time to time without notice. If there is any conflict between the FINANCIAL POLICIES and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, the FINANCIAL POLICIES shall control.

2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.

3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) you receive services in excess of such authorization or referral; (ii) your health plan determines that the services you received are not medically necessary and/or not covered by your insurance plan; (iii) your health plan coverage has lapsed or expired at the time you receive services. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by Stanislaw P. Chorzepa, D.O..

5. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Stanislaw P. Chorzepa, D.O. for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy. any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You

authorize this office and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related lo your treatment (including itemization or any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. This office does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit the same to Stanislaw P. Chorzepa, D.O. until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize this office to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account. or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

7. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.

8. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due.. your account will be in default and auto referred to a collection agency. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower. For small balances, between $4.01 to $25.00, we may stop sending billing statements any time after the initial statement, but you understand that the amount shall remain due and owing until paid in full.

9. We accept payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard or Discover).

a. **Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $30.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize Stanislaw P. Chorzepa,

D.O., if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). PLEASE NOTE: The above language authorizes an electronic debit to your account for the amount of the check plus the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, this authorization is to remain in effect until Stanislaw P. Chorzepa, D.O. has received written notice of termination in such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that Stanislaw P. Chorzepa, 0.0. cannot collect a returned check fee by other methods.

b. **Payment by Credit Card/Credit Card on File.** When you pay by Credit Card to be held on file, you agree to keep the credit card information current, and you authorize our office to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a processed claim in the future. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last 5 digits of your credit card are viewable by personnel. You understand that you are responsible for all charges for services that you receive from Stanislaw P. Chorzepa, D.O., and if the patient responsibility portion of your charges (including charges applied to your deductible and/or coinsurance) is not paid in full within thirty (30) days following receipt of the financial responsibility statement, then Stanislaw P. Chorzepa, D.O will bill your stored credit card for the outstanding balance due.

10. **Managed Care (HMO, PPO, etc.).** All managed care co-payment amounts are due at the time of service. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

11. **Medicare.** Stanislaw P. Chorzepa, D.O. is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

12. **Medicaid.** If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend...clown requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.

13. **Workers' Compensation Cases.** Charges for services incurred as a result of a verified work-related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the

workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

14. **Third Party Liability Injuries.** If you receive treatment as a result of a third party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because Dr. Stanislaw P. Chorzepa, D.O. does not protect charges incurred relating to or arising out of third party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third party insurance payments. We cannot act as administrators to resolve financial arrangements. We may agree to bill a third party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

15. **Ancillary Services.** You may receive ancillary medical services while a patient of Stanislaw P. Chorzepa, D.O. such as EKGs, spirometry testing, etc. By signing below, you understand that some physicians may not provide services in your presence, but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

16. **Additional Charges.** Patients may incur and are responsible for the payment of additional charges at our discretion including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without 24 hours advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.

17. **Non-payment on Account.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Stanislaw P. Chorzepa, D.O. has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party

collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit . transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care. Furthermore, once you are delinquent 90 days or more, at our discretion, this office may require that for future appointments, a deposit of $100 be made for anyone with a deductible and/or an HSA or other credit card be left on tile. Finally, we also reserve the right to withdraw from future care, ie. Dismiss you from the practice for repeated failure to pay bills.

18. **Minor Patients.** The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of this office.

19. **Authorization to Contact.** You authorize personnel of this office to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Stanislaw P. Chorzepa, D.O., or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers to contact you for purposes related to your account, including debt collection. You authorize us to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

20. **Financial Responsibility Party.** If this or a separate Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Stanislaw P. Chorzepa, D.O. of all indebtedness of Patient to Stanislaw P. Chorzepa, D.O., whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise. incurred by Stanislaw P. Chorzepa, D.O. in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Stanislaw P. Chorzepa. D.O. at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of the Financial Responsibility Party.

Financial Policy Acknowledgment

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of this PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to specified terms; (ii) I agree to pay all charges due (or to become due) to Stanislaw P. Chorzepa, D.O. for the below Patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any service rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

It is Dr. Chorzepa's policy that each patient should get a physical every year in order to remain a patient in good standing. There are many benefits to having preventive health visits and also helps develop a trust and relationship with your physician. This visit is in addition to any visits pertaining to a chronic problem including diabetes, hypertension, high cholesterol, heart conditions, hyper/hypothyroidism, etc. I understand that I will be requested to schedule an annual physical examination.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original. ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

Signature of Patient/Responsible Party/Guardian Date

_____ _____

Printed Name Date of Birth

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient/Responsible Party/Guardian Date

_____ _____

Printed Name Date of Birth

Social Determinants

1. **Jaka jest Twoja sytuacja mieszkaniowa?**

   ☐ Nie mam mieszkania (przebywam z innymi, w hotelu, schronisku, mieszkam na ulicy, na plaży, w opiece, opuszczonym budynku, na dworcu autobusowym lub kolejowym, w parku)
   ☐ Mam dziś mieszkanie, ale obawiam się, że w przyszłości go stracę
   ☐ Mam mieszkanie

2. **Pomyśl o miejscu, w którym mieszkasz. Czy masz jakieś problemy z którymkolwiek z poniższych? (zaznacz wszystkie pasujące)**

   ☐ Robaki
   ☐ Pleśń
   ☐ Farba ołowiowa lub rury
   ☐ Niedostateczne ciepło
   ☐ Niedziałająca kuchenka
   ☐ Brak lub nie działają czujniki dymu
   ☐ Wycieki wody
   ☐ Żadne z powyższych

3. **W ciągu ostatnich 12 miesięcy martwiłeś/aś się, że skończy Ci się żywność, zanim zdobędziesz pieniądze na kolejne zakupy.**

   ☐ Często
   ☐ Czasami
   ☐ Nigdy

4. **W ciągu ostatnich 12 miesięcy zabrakło Ci jedzenia i nie miałeś pieniędzy żeby je kupić.**

   ☐ Często
   ☐ Czasami
   ☐ Nigdy

5. **Czy w ciągu ostatnich 12 miesięcy brak transportu powstrzymał Cię przed wizytami lekarskimi, spotkaniami, pracą lub na zakupy? (zaznacz wszystkie pasujące)**

   ☐ Tak, powstrzymało mnie to przed wizytami lekarskimi i otrzymywaniem leków
   ☐ Tak, powstrzymało mnie to przed spotkaniami niezwiązanymi z medycyną, wizytami, pracą lub dostawaniem rzeczy, których potrzebowałem/am
   ☐ Nie

6. **Czy w ciągu ostatnich 12 miesięcy firma elektryczna, gazowa, wodociągowa i wodna groziła wyłączeniem usług w Twoim domu?**

   ☐ Tak
   ☐ Nie
   ☐ Już odcięto usługi

7. **Jak często ktoś, w tym rodzina, fizycznie Cię skrzywdzi?**

☐ Nigdy
☐ Rzadko
☐ Czasami
☐ Dość często
☐ Często

8. **Jak często ktoś, w tym rodzina, obraża Cię lub dyskutuje z Tobą?**

☐ Nigdy
☐ Rzadko
☐ Czasami
☐ Dość często
☐ Często

9. **Jak często ktoś, łącznie z rodziną, groził Ci krzywdą?**

☐ Nigdy
☐ Rzadko
☐ Czasami
☐ Dość często
☐ Często

10. **Jak często ktoś, łącznie z rodziną, krzyczy lub przeklina cię?**

☐ Nigdy
☐ Rzadko
☐ Czasami
☐ Dość często
☐ Często

11. **Czy potrzebujesz pomocy?**

☐ Tak
☐ Nie

ANKIETA NIEPOKOJU

(Anxiety Questionnaire)

W ciągu ostatnich 2 tygodni, jak często borykałeś się z poniższymi problemami?

	Nigdy	Parę dni	Więcej niż połowe dni	Każdego dnia
Nerwowość, uczucie niepokoju lub bycia na krawędzi	**0**	**1**	**2**	**3**
Niemożliwość zastopowania uczucia zamartwiania się	**0**	**1**	**2**	**3**
Zbyt duże zamartwianie się o różne rzeczy	**0**	**1**	**2**	**3**
Kłopoty z odprężeniem się	**0**	**1**	**2**	**3**
Bycie tak niespokojnym, że trudno spokojnie usiedzieć w miejscu	**0**	**1**	**2**	**3**
Łatwo się denerwowałem/am lub irytowałem/am	**0**	**1**	**2**	**3**
Boję się, że zdarzy się coś okropnego	**0**	**1**	**2**	**3**

Total: _____

NEW PATIENT
MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:		Last Pnuemovax *(Pneumonia)*:	
Last Flu Vaccine:		Last Prevnar:	
Covid-19 Vaccine - Manufacturer:		Last Zoster Vaccine *(Shingles)*:	
Date of 1st Dose:	Date of 2nd Dose:	Booster - Manufacturer:	Date:

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

OTHER HEALTH ISSUES continued...

EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?		***Duration:*** How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Is violence at home a concern for you? Y N	Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Palpitations	Rash
Diaphoresis	**Gastrointestinal**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental allergies
Unexpected weight change	Anal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Polydipsia	Syncope
Postnasal drip	Polyphagia	Tremors
Rhinorrhea	Polyuria	Weakness
Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Adenopathy
Sore throat	Dysuria	Bruises/bleeds easily
Tinnitus	Enuresis	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Hematuria	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations
Eye redness	Penile swelling	Hyperactive
Photophobia	Scrotal swelling	Nervous/anxious
Visual disturbance	Testicular pain	Self-injury
RESPIRATORY	Urgency	Sleep disturbance
Apnea	Urine decreased	Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Arthralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	

Patient Name: _____ DOB: _____