

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,



Dr. Stanislaw P. Chorzepe & Staff

PATIENT DEMOGRAPHIC FORM

Please print. All information will be confidential.

NAME: _____ DOB: ____/____/____
Last First Middle

ADDRESS: _____
Street City State Zip Code

Gender: Male Female Prefer not to disclose SOCIAL SECURITY NUMBER: _____ - _____ - _____

Race

White

Black

Asian

Other: _____

Ethnicity

Non-Hispanic

Hispanic

Preferred Language

English

Polish

Spanish

Other: _____

Smoking Status

Never Smoked

Quit Smoking/When? _____

Current Occasional Smoker

Current Daily Smoker

Marital Status: Married Single Separated Widow(ed) Divorced Partnered

Preferred Pharmacy: Name _____ Town _____

TELEPHONE NUMBER

Home: _____ May we leave a message on this number? Yes No

Cell: _____ May we leave a message on this number? Yes No

Work: _____ Email Address: _____

DO YOU WANT APPOINTMENT REMINDERS VIA EMAIL OR PHONE ? (if phone: home / cell / work)
circle one

Employer Name: _____

Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Subscriber's Name: _____

Relation to subscriber: self spouse dependent

Policy# _____

Group# _____

Secondary Insurance Carrier: _____

Subscriber's Name: _____

Relation to subscriber: self spouse dependent

Policy# _____

Group# _____

EMERGENCY CONTACT

(if we cannot reach you)

Name: _____ Relation: _____ Phone#: _____

CHECK HERE IF THIS VISIT IS DUE TO MVA OR WORKER'S COMPENSATION

CLAIM NUMBER: _____

I authorize Dr. Stanislaw P. Chorzepa to release my medical records, date or information requested by my medical insurance carrier so that my medical claims may be processed.

Signature: _____ Date: _____

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 #: _____

<p>Information may be <input type="checkbox"/> Disclosed <u>to</u> Below Facility <input type="checkbox"/> Obtained <u>from</u> Below Facility</p> <p>Name/Facility: _____ Mailing Address: _____ City/State/Zip: _____ Phone #: (____) _____ Fax #: (____) _____</p> <p><input type="checkbox"/> Hand/Carry <input type="checkbox"/> Mail <input type="checkbox"/> Fax</p>	<p>Information may be <input type="checkbox"/> Disclosed <u>to</u> Below Facility <input type="checkbox"/> Obtained <u>from</u> Below Facility</p> <p style="text-align: center;">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</p>								
<p><u>The purpose of this disclosure or use is for the following reason:</u></p> <p><input type="checkbox"/> Transfer of Care <input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient or legal representative <input type="checkbox"/> Other (please specify) _____</p> <p><u>Dates of service of information to be used or disclosed:</u> _____</p>	<p><u>Requested Information:</u></p> <p><input type="checkbox"/> Complete Record</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> History & Physical</td> <td><input type="checkbox"/> Laboratory Report</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> EKG Report</td> </tr> <tr> <td><input type="checkbox"/> Operative Reports</td> <td><input type="checkbox"/> X-Ray Report</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Billing Statement</td> </tr> </table> <p><input type="checkbox"/> Other: _____</p>	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> X-Ray Report	<input type="checkbox"/> Consultations	<input type="checkbox"/> Billing Statement
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Report								
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG Report								
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> X-Ray Report								
<input type="checkbox"/> Consultations	<input type="checkbox"/> Billing Statement								

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, part 2. 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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For the ease of our patients, our office would like to offer the opportunity to communicate health information by email and text messages. By signing below your provider may share payment and health information with you through e-mail and text message regarding billing, diagnosis, treatment, lab results, and radiology reports.

I know that I am under no obligation to authorize the office of Dr. Stanislaw P. Chorzepa to send me e-mails or text messages. I understand that e-mails and text messaging are not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such e-mail or text message may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in e-mails or text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

- Employers and on-line services have the right to access and archive e-mail or text messages transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.
- E-mail and text messages are best suited for routine matters and simple questions. You should not send us e-mail or text messages for urgent or emergency situations or for matters requiring an immediate response. Your provider's representative (office staff) will attempt to read and respond promptly to e-mail or text messages but cannot guarantee that any particular e-mail or text message will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.
- If your e-mail requires or asks for a response and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with Dr. Stanislaw Chorzepa's office.
- You should carefully consider the use of e-mail for the communication of sensitive medical information such as but not limited to; information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mails and text messages between you and your provider regarding diagnosis or treatment may be printed and made part of your permanent health information.

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 to 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, D.O. 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...down 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 file. 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; (iii) 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

Social and economic issues can impact your health. Because of this, we are interested in knowing whether you have any concerns that might need to be addressed by helping with these concerns. Please answer the following questions so that we can understand how we can best help you address your medical records

1. What is your housing situation today?

- I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a care, abandoned building, bus or train station, or in the park)
- I have housing today, but I am worried about losing housing in the future
- I have housing

2. Think about the place you live. Do you have any problems with any of the following? (check all that apply)

- Bug infestation
- Mold
- Lead paint or pipes
- Inadequate heat
- Oven or stove not working
- No or not working smoke detectors
- Water leaks
- None of the above

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

4. Within the past 12 months, the food you bought didn't last you and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)

- Yes, it kept me from medical appointments or getting medications
- Yes, it kept me from non-medical meetings, appointments, work, or getting things that I needed
- No

6. In the past 12 months has the electric gas, oil, or water company threatened to shut off services in your home?

- Yes
- No
- Already shut off

7. How often does anyone, including family, physically hurt you?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

8. How often does anyone, including family, insult or talk down to you?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

9. How often does anyone, including family, threaten you with harm?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

10. How often does anyone, including family, scream or curse at you?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

11. Do you need any help?

- Yes
- No

NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS <i>(Please list ALL)</i>	DOSE <i>(Mg., pill, etc.)</i>	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 (<i>Pneumonia</i>):	
Last Flu Vaccine:		Last Prevnar:	
Covid-19 Vaccine - Manufacturer:		Last Zoster Vaccine (<i>Shingles</i>):	
Date of 1st Dose:	Date of 2nd Dose:	Booster - Manufacturer:	Date:

PERSONAL MEDICAL HISTORY

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

SURGERIES

TYPE (<i>specify left/right</i>)	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):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> 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 <i>(If you answered no, please move to Sleep)</i>	
What kind of exercise?		Duration: How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night <i>(or during the day, if working night shift)</i> ?	
DIET	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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: _____