GENESIS MEDICA, LLC

PATIENT INFORMATION FORM

FORMS MUST BE FILLED IN **ENTIRELY**

DATE: _____

PATIENT INFO

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB:_____

PHONE NUMBER: [H] _____ [C] _____ [W] _____

STREET ADDRESS: _____ APT #_____ CITY: _____STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ SEX: ☐M ☐F ☐T EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____ ☐FULL-TIME ☐PART-TIME ☐UNEMPLOYED

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

SPOUSE'S NAME: _____ SPOUSE'S DOB: _____

DO YOU HAVE A LIVING WILL / ADVANCE DIRECTIVE? ☐YES ☐NO

ETHNICITY: ☐HISPANIC/LATINO ☐ NON-HISPANIC RACE: _____ LANGUAGE: _____

EMERGENCY CONTACT

NAME: _____ PHONE #:_____ RELATION: _____

GUARANTOR / PATIENT INFORMATION

NAME: _____ DOB: _____ RELATION: _____

☐ INSURANCE INFORMATION ☐ SELF-PAY

PRIMARY INSURANCE NAME: _____ ID #: _____

POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INSURANCE NAME: _____ ID #: _____

POLICY HOLDER NAME: _____ DOB: _____

AUTHORIZATIONS – TREATMENT/MEDICAL RECORDS/BILLING CONSENT

AUTHORIZATION AND RELEASE FOR GENESIS MEDICA, LLC-I VOLUNTARILY CONSENT TO THE ADMINISTRATION AND COSTS OF MEDICAL AND/OR SURGICAL PROCEDURES FOR MYSELF OR MY DEPENDENT.

ASSIGNMENT OF INSURANCE BENEFITS / GUARANTEE OF PAYMENT
I AUTHORIZE PAYMENT DIRECTLY TO GENESIS MEDICA, LLC FOR ALL BENEFITS PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY ALL CHARGES THAT ARE NOT PAID OR BILLED TO INSURANCE OR ANY THIRD PARTY PAYER. I UNDERSTAND THAT I MUST PAY IN FULL TODAY FOR ALL SERVICES RENDERED UNLESS MY INSURANCE IS ACCEPTED. I ALSO UNDERSTAND THAT IF MY INSURANCE IS ACCEPTED I UST PAY ALL APPLICABLE INSURANCE CO-PAYS, OR CO-INSURANCE, AND DEDUCTIBLE FOR SERVICES. I UNDERSTAND ALL SERVICES RENDERED ARE NON-REFUNDABLE UNDER ANY CIRCUMSTANCE. I UNDERSTAND THAT IF I DO NOT PAY WITHIN 90 DAYS UPON RECEIPT OF MY BILLING STATEMENT, MY ACCOUNT WILL BE TRANSFERRED OVER TO A CREDIT COLLECTION AGENCY.

RELEASE OF RECORDS
I AUTHORIZE GENESIS MEDICA, LLC TO RELEASE (VERBAL OR WRITTEN) CONFIDENTIAL MEDICAL INFORMATION TO ANY PERSON OR ENTITY INCLUDING MY INSURANCE CARRIER, EMPLOYER [IF TREATMENT IS RELATED TO EMPLOYER PURPOSES], OR OTHER HEALTH CARE OPERATIONS WHICH MAY BE LIABLE TO ME OR MY PRACTITIONER(S) FOR CHANGES FOR THE TREATMENT AND FOR QUALITY MANAGEMENT, UTILIZATION REVIEW, TRANSFER, AND FOLLOW-UP PURPOSES. I ALSO HEREBY AUTHORIZE GENESIS MEDICA, LLC TO CHECK MY EXTERNAL RX HISTORY FOR PURPOSES OF TREATMENT. I ALLOW GENESIS MEDICA, LLC TO RETRIEVE, REVIEW AND SEND MY MEDICAL RECORDS VIA ELECTRONIC HEALTH RECORDS SYSTEMS.

SIGNATURE: _____**DATE:** _____

RELATIONSHIP TO PATIENT: _____

GENESIS MEDICA, LLC

MEDICAL HISTORY

[PLEASE FILL IN COMPLETELY, ALL INFORMATION IS REQUIRED]

REASON FOR VISIT: _____ DATE: _____

LAST NAME: _____ FIRST: _____ MI:_____ DOB: _____/_____ /_____

GENDER: ☐M ☐F ☐T BEST PHONE NUMBER TO REACH YOU: _____ ☐HOME ☐CELL ☐WORK ☐OTHER

HOW DID YOU HEAR ABOUT US? _____

WHICH PHARMACY DO YOU USE?: _____ LOCATION: _____

CURRENT MEDICATION(S): ☐ NONE

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

MEDICATION ALLERGIES: ☐ NONE ☐YES:_____

OTHER ALLERGIES: _____

HAVE YOU EVER HAD AN ALLERGY TEST? ☐ NO ☐ YES IF YES, WHEN? _____ WHERE?_____

MEDICAL HISTORY: ☐DOES NOT APPLY ☐DEPRESSION ☐KIDNEY DISEASE ☐HEART DISEASE ☐ANEMIA ☐SEIZURES ☐DIABETES
☐CANCER (TYPE) _____ ☐HIGH BLOOD PRESSURE ☐THYROID DISORDER ☐ASTHMA ☐HIGH CHOLESTEROL
OTHER(S) EXPLAIN: _____

SURGICAL HISTORY: ☐ NONE

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

FAMILY HISTORY: ☐NONE ☐DEPRESSION ☐KIDNEY DISEASE ☐HEART DISEASE ☐ANEMIA ☐SEIZURES ☐DIABETES

☐CANCER (TYPE) _____ ☐HIGH BLOOD PRESSURE ☐THYROID DISORDER ☐ASTHMA ☐HIGH CHOLESTEROL

OTHER(S) EXPLAIN: _____

SOCIAL HISTORY: ☐NONE SMOKER? ☐ NO ☐ YES, PACKS PER DAY?:_____ LENGTH OF USE? _____

SUBSTANCE ABUSE? ☐ NO ☐ YES IF YES, LIST SUBSTANCE(S): _____ LENGTH OF USE? _____

ALCOHOL ABUSE? ☐ NO ☐ YES IF YES, HOW MUCH? _____LENGTH OF USE? _____

CAFFEINE INTAKE? ☐ NONE ☐1-2 CUPS PER DAY ☐ 2-3 CUPS/DAY ☐ 3-4 CUPS PER DAY ☐ MORE THAN 4 CUPS PER DAY

FALL HISTORY: (PATIENTS OVER 65) HOW MANY FALLS HAVE YOU HAD IN THE **PAST YEAR**? ☐NONE ☐ONE FALL WITH INJURY ☐TWO OR MORE FALLS ☐ONE FALL WITHOUT INJURY ☐TWO OR MORE FALLS WITHOUT INJURY

LAST **MAMMOGRAM**, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY
LAST **COLONOSCOPY**, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY
LAST **INFLUENZA (FLU) VACCINE**, WHEN AND WHERE? _____ ☐NEVER
LAST **PNEUMONIA VACCINE**, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY
DIABETIC PATIENTS: LAST EYE EXAM, WHEN AND WHERE? _____ ☐NEVER ☐DOES NOT APPLY

OFFICE USE ONLY

CHIEF COMPLAINT: _____

BP _____ TEMP _____ PR _____ RR _____ O2 _____ HT _____ WT_____ LMP: _____
FLU _____ STREP _____ MONO _____ OTHER TESTING/RESULTS: _____

GENESIS MEDICA, LLC

FINANCIAL AGREEMENT

Patient's Printed Name: _____ SS # _____

IMPORTANT: THIS IS NOT AN APPLICATION FOR CREDIT. CHARGES FOR ALL SERVICES RENDERED BY **GENESIS MEDICA, LLC AND AFFILIATIONS** ARE DUE AND PAYABLE IN FULL SIXTY (60) DAYS FROM THE DATE SERVICES WERE RENDERED. We will assist the Patient in the processing of insurance claims as a courtesy only. We accept no responsibility for any processing procedures, acts, omissions and/or neglect. PATEINT AND RESPONSIBLE PARTY ARE SOLELY RESPONSIBLE TO PAY FOR ALL SERVICES PROVIDED.

IN CONSIDERATION of the provision of services to the Patient, named herein, the Patient and the responsible party understand and agree that:

1. Payment for services rendered is due in full sixty (60) days from the date services were rendered. Any **balance unpaid after sixty (60) days** from the date services were rendered will be considered "delinquent".

2. The Patient and responsible party must pay all costs of collection, including reasonable attorney's fees, if the delinquent balance is referred to an attorney for collection.

3. **ANY BALANCE UNPAID AFTER NINETY (90) DAYS FROM THE DATE SERVICES WERE RENDERED WILL BE SUBJECT TO INTEREST AT THE ANNUAL PERCENTAGE RATE OF TEN (10%) PERCENT WHEN THE ACCOUNT HAS BEEN PLACED FOR COLLECTION.**

4. In the event the Patient submits payment by check and that check is returned for **"INSUFFICIENT FUNDS"** by the bank, we will add Twenty ($20.00) Dollars to the balance owed by the Patient.

5. This Agreement shall be binding upon the Patient and responsible party for all charges incurred by the Patient for a Two (2) year period from the date of this Agreement.

6. No statement by an employee or agent of ours will contradict, void or nullify this Agreement, nor shall the Patient rely on any statements or opinions made by us that an insurance carrier will pay the bill.

Authorization is hereby given to **GENESIS MEDICA, LLC and AFFILIATIONS** to submit my claim directly to my insurance on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to **GENESIS MEDICA, LLC and AFFILIATIONS**.

I HEREBY AUTHORIZE YOU TO RELEASE ALL MEDICAL AND BILLING INFORMATION NECESSARY TO SECURE PAYMENT FROM ANY INSURANCE CARRIER ON MY BEHALF.

I have read and fully understand all of the above conditions. Once I sign this agreement, I am responsible for all charges, and if necessary, costs of collection and a reasonable attorney's fee, as stated above.

I acknowledge receipt of a copy of this agreement. **DATED:** _____

PATIENT/RESPONSIBLE PARTY SIGNATURE : _____

RESPONSIBLE PARTY (If other than patient): _____ **RELATIONSHIP TO PATIENT:** _____

WITNESS: _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Consent of Notifications

I give permission to Genesis Medica, LLC to notify_____[Full Name/Relationship] with my health information.

I give permission to Genesis Medica, LLC to leave any health-related information in my voice mailbox.

If you will be contacting me regarding an appointment, lab or other tests, consultations, I prefer you call this phone number:

(____)_____HOME / CELL / WORK

Patient Name_____

Relationship to Patient _____

Signature_____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____Initials:_____Reason: _____

HEALTH INFORMATION EXCHANGE (HIE)
PATIENT AUTHORIZATION FORM

Patient Informati			
	Last Name:	First Name:	Middle:
	Date of Birth:	Other Possible Names:	
	Phone #:	Street Address:	
	City:	State:	Zip:

A Health Information Exchange ("HIE") is a safe way for health care providers to get the most up-to-date health information about you. The HIE will allow Genesis Medica, LLC and affiliates to access or share your health information with other healthcare providers. This may improve your overall care through the use of an electronic medical record. By signing this form, you are agreeing that your health information, including test results, lab reports, X-rays, medication lists or any other relevant electronic health information may be shared across participating health care providers.

You acknowledge that you read this form, was given opportunity to ask questions and got answers you understood.

1. I understand that this authorization will expire one year from the date of my signature below.
2. I understand that I may revoke this authorization at any time by submitting a *Patient Withdraw Authorization* Form and submitting it to Genesis Medica, LLC in writing. I understand that if I withdraw authorization, no new health information may be shared with the HIE and the health information already submitted to the HIE may not be used unless it already has been used in reliance on my previous authorization. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to t his authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state and federal laws may prohibit the recipient from disclosing specially protected information, such as such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. I understand that my refusal to sign this authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my health information is required for the provision of healthcare or to obtain payment for healthcare.
5. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as valid as the original.

_____ _____

Print Name of Patient | Print Date of Birth

_____ _____

Signature of Patient/Legal Representative | Date Time

_____ _____

Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)

MEDICARE PATIENTS ONLY

A. Notifier: Genesis Medica, LLC/Sanjay Aggarwal, MD, LLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for services listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
• Preventative Physical examination (Yearly routine physical) • Colorectal Cancer Screening; Fecal-Occult Blood Test (covered only once per calendar year) • Vaccinations (except Flu and Pneumonia shots)	• Medicare does not usually pay for these services • Medicare does not usually pay for these shots • Medicare usually does not pay for this lab test • This procedure is not covered under Medicare's policy Beneficiary Notice	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Patient Name: _____ Date: _____

DRUG ABUSE SCREENING TEST - DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes ☐	No ☐
2	Do you abuse more than one drug at a time?	Yes ☐	No ☐
3	Are you unable to stop using drugs when you want to?	Yes ☐	No ☐
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes ☐	No ☐
5	Do you ever feel bad or guilty about your drug use?	Yes ☐	No ☐
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes ☐	No ☐
7	Have you neglected your family because of your use of drugs?	Yes ☐	No ☐
8	Have you engaged in illegal activities in order to obtain drugs?	Yes ☐	No ☐
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes ☐	No ☐
10	Have you had mental problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes ☐	No ☐

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior-feedback and advice
3-5	Moderate level	Harmful behavior-feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

GENESIS MEDICA

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "***X***" to indicate your answer.)

	NOT AT ALL 0	SOME DAYS 1	MOST DAYS 2	NEARLY EVERY DAY 3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling asleep or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could notice; or the opposite, being so fidgety or restless that you have been moving around more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐
Totals				
TOTAL SCORE:	_____			

Interpretation:

☐1-4 -Minimal Depression
☐5-9 -Mild Depression
☐10-14 -Moderate Depression
☐15-19 –Moderately Severe Depression
☐20-27 –Severe Depression

GENESIS MEDICA

ALCOHOL USE DISORDERS IDENTIFICATION TEST-CONCISE (AUDIT-C)

Patient Name: _____ Date: _____

(Use "***X***" to indicate your answer.)

1. How often do you have a drink containing alcohol?

   ☐ Never
   ☐ Monthly or less
   ☐ 2-4 times a month
   ☐ 2-3 times a week
   ☐ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

   ☐ 1 or 2
   ☐ 3 to 4
   ☐ 5 to 6
   ☐ 7 to 9
   ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

   ☐ Daily or almost daily
   ☐ Weekly
   ☐ Monthly
   ☐ Less than monthly
   ☐ Never