INTAKE FORM

Date: _____ Referred by: _____

Patient Full Name: _____ Gender: ☐M ☐F ☐ Other

Birth Date:____/_____/_____Height:_____Weight:_____Age_____

Social Security #:_____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: (____) _____ Cellular Phone: (____) _____

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Occupation:_____

Current Primary Care Physician: _____

Pharmacy (Name and Address): _____

****

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's ID: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Relationship to subscriber (if applicable): _____

Secondary Insurance: _____ Subscriber's ID_____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Relationship to subscriber (if applicable): _____

****

EMERGENCY CONTACT

Name: _____ Phone#:_____Relationship:_____

****

CHIEF COMPLAINT (PROBLEM AREA FOR INITIAL VISIT):

_____

_____

_____

HISTORY OF THE PRESENT ILLNESS:

How long has the illness been present? Was there an injury or trauma?

_____

Quality of pain: (If one of these does not apply, please leave blank)

	Occasional	Continuous		Occasional	Continuous
Aching	☐	☐	Numb	☐	☐
Throbbing	☐	☐	Nagging	☐	☐
Shooting	☐	☐	Penetrating	☐	☐
Stabbing	☐	☐	Constant	☐	☐
Sharp	☐	☐	Burning	☐	☐
Tender	☐	☐	Unbearable	☐	☐

What makes the pain better? _____

What makes the pain worse? _____

PAIN RATING:

On a scale of 0 – 10, rate your pain: (Please circle the number that best describes your pain)

No Pain Severe Pain

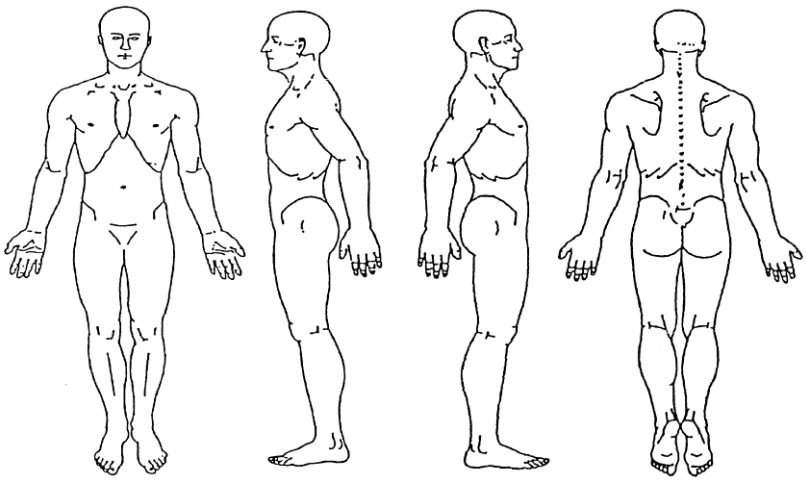
0 1 2 3 4 5 6 7 8 9 10

Please use the symbols below to accurately mark the areas in which you feel these sensations:

Stabbing/Cutting-//// Tingling-**** Burning-XXXX Cramping- ^^^^

Numbness-NNNN

Dull-####



How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying down	☐	☐	☐	_____
Looking up	☐	☐	☐	_____
Looking down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____
Bending/Twisting	☐	☐	☐	_____

PROGRESSION:

How is your pain compared to when the pain episode first started?
☐ Much Improved ☐ Somewhat Improved ☐ Much Worse ☐ Somewhat Worse ☐ No Change

Does this pain interrupt your sleep?
☐ Yes ☐ No

CARE TEAM (PLEASE CHECK AND NAME YOUR OTHER DOCTORS):

☐ Orthopedist _____ ☐ Chiropractor _____
☐ Neurologist _____ ☐ Pain Management _____
☐ Psychiatrist _____ ☐ Primary Care _____
☐ Physical Therapist _____ ☐ Cardiologist _____
☐ Other _____

List the treatments you have had for your problem:

☐ Chiropractic ☐ Physical Therapy ☐ Inversion/ Traction
☐ Trigger Point Injections ☐ Epidural/Facet Injections ☐ Radio Frequency Ablation
☐ Acupuncture ☐ Hot/ Ice packs ☐ Strengthening Exercises
☐ Electrical Stimulation ☐ Massage Therapy ☐ Other _____

How effective is treatment? ☐ Temporary relief ☐ Very helpful ☐ Not helpful Frequency? _____

List the types of Diagnostic Testing that has been performed for this problem:
☐ X-Rays ☐ C.T. Scan ☐ Myelogram ☐ M.R.I. Scan ☐ Discogram
☐ Bone Scan ☐ E.M.G. ☐ N.C.S.
What body parts were imaged? _____

Depression Inquiry:
Do you have any feelings of sadness? ☐ Yes ☐ No

Are you having crying spells? ☐ Yes ☐ No
Are you withdrawing from social situations? ☐ Yes ☐ No
Are you enjoying activities that you normally enjoyed in the past? ☐ Yes ☐ No
Are you having any thoughts of suicide? ☐ Yes ☐ N

MEDICAL HISTORY:

List any medications you are currently taking with the frequency and dosage:

_____

_____

_____

ALLERGIES:_____

_____

PAST MEDICAL HISTORY:

Please mark a ✓ to indicate if you have had any of the following:

☐ High blood pressure
☐ High cholesterol
☐ Heart disease
☐ Depression/Anxiety
☐ Mental illness
☐ Alcohol/Drug abuse
☐ Multiple Sclerosis
☐ Scoliosis
☐ Anemia
☐ GERD/ Acid Reflux
☐ Arthritis
☐ Hernia
☐ Gout
☐ Migraine headaches
☐ Herniated disc/ Slipped disc
☐ Pneumonia
☐ Glaucoma
☐ Suicide attempt
☐ Gonorrhea
☐ AIDS/HIV
☐ Clotting Disorders / Bleeding disorders
☐ Cancer (Type:_____)
☐ Pacemaker
☐ Heart attack
☐ Stroke
☐ Diabetes
☐ Neurological Problems (Seizures, Parkinson's)
☐ Kidney problem
☐ Lung problem/Emphysema/COPD
☐ Liver/Gallbladder Disease
☐ Ulcer/Stomach
☐ Thyroid/Endocrine
☐ Prostate/Ovary Issues
☐ Rheumatoid Arthritis
☐ Prosthesis
☐ Hepatitis
☐ Herpes
☐ Mononucleosis
☐ Osteoporosis
☐ Head Injury
☐ Aneurysm
☐ Skin disease
☐ Immune Disorder
☐ Other: _____

List Past Surgeries: ☐ None

_____

_____

List previous back, neck and musculoskeletal problems:

_____

_____

FAMILY HISTORY:

Please mark a ✓ to indicate if anyone in your immediate family (Mother, Father, Siblings) has or had any of the following:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Cancer
- ☐ Arthritis
- ☐ Heart attack
- ☐ Stroke
- ☐ Diabetes
- ☐ Mental illness
- ☐ Depression
- ☐ Other _____

SOCIAL HISTORY:

- ☐ Non-Smoker
- ☐ Smoker (Quantity) _____
- ☐ Former Smoker / Quit _____
- ☐ Do not drink alcohol
- ☐ Drink alcohol How much? _____ How often? _____
- ☐ Does not take drugs
- ☐ Drug use (past or present) ☐ THC ☐ Cocaine ☐ Other illegal drugs

REVIEW OF SYSTEMS:

Please mark a ✓ to indicate if you have had any of the following:

General: ☐ Fever ☐ Chills ☐ Unexplained Weight Change ☐ Other _____

Skin: ☐ Rashes ☐ Lumps ☐ Other_____

Musculoskeletal: ☐Muscle/Joint Pain ☐ Joint Swelling ☐ Muscle Aches ☐ Other_____

Head: ☐ Headaches ☐ Head Pain ☐ Other_____

Eyes: ☐ Changes in Vision ☐ Glaucoma ☐ Double Vision ☐ Other_____

Ears: ☐ Decreased Hearing ☐ Ringing ☐ Other_____

Mouth and Throat: ☐ Bleeding ☐ Tooth Pain ☐ Other_____

Neck: ☐ Hoarseness ☐ Other_____

Nodes: ☐ Enlargement ☐ Tenderness ☐ Other_____

Breasts: ☐ Lumps ☐ Pain ☐ Discharge ☐ Other_____

Respiratory: ☐ Coughing ☐ Shortness of Breath ☐ Other_____

Cardiovascular: ☐ Chest Discomfort ☐Palpitations ☐ Shortness of Breath ☐ Other_____

Gastrointestinal: ☐ Difficulty Swallowing ☐ Rectal Bleeding ☐ Other_____

Urinary: ☐ Frequency ☐ Urgency ☐ Other_____

Hematological: ☐ Ease of Bruising ☐ Ease of Bleeding ☐ Other_____

Medical Records Release, Treatment and Payment Authorization

I hereby authorize the Boev Clinic and/or associate(s) to provide treatment as well as furnish information regarding my illness and treatment for insurance authorization. I also authorize the above to release information to my family physician, referring physician and any other medical facility as required. The information I have provided is true. I understand that I am financially responsible for any co-pay, co-insurance, and surgery or office visit balance not covered by my insurance carrier/workers compensation/no fault. I agree to pay said balance in a timely fashion. I am responsible to contact the insurance carrier to determine my financial obligations.

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.

I request the payment of authorized Medicare benefits be made either to me or my behalf to this office for the services furnished by that physician to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payables for related services. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Printed Name: _____ Date: _____

Signature: _____

SureScripts Authorization:

SureScripts allows us to access your pharmacy information thus allowing us to:

- Send and receive prescriptions online from your pharmacy
- Keep an accurate, up-to-date medication list
- Alert the Provider of any drug interactions or contraindications

I give consent to retrieve and use my medication history from SureScripts.

Printed Name: _____ Date: _____

Signature: _____

Boev Medical, PLLC

HIPAA Communication Form

Disclosure to Self and Others

Patient Name: _____ **Patient DOB:**_____

A. **Family and Friends:** It is the office policy of Boev Medical, PLLC, not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

   If you anticipate that you will need or want your medical information to be provided to authorized family members, friends, or caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following person to receive information as requested, regarding your care and treatment. Updates to this form must be made in person, please ask for additional forms if you need room for more people.

Name	Relationship	Phone

Name	Relationship	Phone

B. **Alternative Communication:** I allow the office of Boev Medical, PLLC, to contact me using the following methods with the contact information I provided: appointment reminders, text messages, emails, written mailed communication, voicemail messages. I am aware that this may contain sensitive information and allow them to contact me in these manners, unless otherwise noted. (Please circle)

Home Phone **Cell Phone** **Email** **US Mail**

C. **Restrictions:** Please fill out the space below with any restrictions you may have regarding our communication:

_____

_____

Signature of Patient or Legal Guardian	Relationship to Patient	Date

HIPAA Form	FACILITY: Boev Medical, PLLC
PRIVACY RULES	LEGAL REFERENCE: Privacy Rules – 45 CFR 164.520
PRIVACY NOTICE ACKNOWLEDGMENT OF RECEIPT	INITIAL EFFECTIVE DATE: April 14, 2003
	LATEST REVISION DATE: August 1, 2019

PRIVACY NOTICE ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Boev Medical, PLLC's Privacy Notice that has an effective date of August 1, 2019.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Name of Personal Representative (Printed) Signature of Personal Representative

_____

Relationship of Personal Representative

Payment Agreement

Patient Name: _____ Date of Birth: _____

INSURANCE: Boev Medical, PLLC participates in most insurance plans including Medicare and Medicaid. If you are not insured by an insurance plan we participate with, then payment in full is expected at each visit. If you are insured by an insurance plan we do participate with, but don't have an up-to-date insurance card, payment in full for each visit is expected until we can verify your coverage. Knowing your plan benefits is your responsibility. Please contact your insurance plan with any questions you have regarding your covered benefits.

CO-PAYS/DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This requirement is part of your contract with your insurance plan. Failure on our part to collect co-payments and deductibles can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you have an insurance plan with a high deductible or one with a co-insurance amount, please be advised that you may be responsible for paying your insurance plan's portion (roughly half of what we bill your plan) until that deductible has been met. Due to the varying complexities of each insurance plan, we are only able to provide you with an ESTIMATE of what you may owe. If you haven't met your deductible, we require new patients to pay $150.00 per visit and follow up patients to pay $75.00 per visit. If we find that we have overcharged you after your insurance plan has processed your claim, we will provide you with a refund. If we find that we have undercharged you we will mail you an itemized statement and you will be responsible for the balance due for each visit.

NON-COVERED SERVICES: Please be aware that some of the services you receive may be considered non-covered services or may not be deemed reasonable, medically necessary, or eligible for benefits by Medicare or other plans. By signing this Agreement, you certify that our practice has notified you in advance of providing any such non-covered services and that you have chosen to consent to obtain the non-covered services nevertheless. You must pay for these non-covered services in full at the time of the visit.

PROOF OF INSURANCE; All patients must complete our patient information form with active plan information before seeing their provider. If you fail to provide us with active plan information in a timely manner, you may be responsible for the balance of any claim.

UNVERIFIED INSURANCE COVERAGE: Our staff will attempt to verify each patient's insurance plan coverage at the time of service. If we cannot verify your insurance plan coverage, you will be required to pay for the visit prior to seeing your provider. New patients will be required to pay $250.00, follow up patients will be required to pay $150.00. If active insurance is provided after payment has been made, we will submit your claim to your insurance plan. Once payment has been received, any remaining credits will be refunded to you.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claim processed. Your insurance plan may need you to supply certain information directly. It is your responsibility to comply with their request.

COVERAGE CHANGES: If your insurance plan changes, please notify us prior to your next visit so that we can make the appropriate changes to help you receive your maximum benefits.

NONPAYMENT: If your account is over 90 days past due, your account will be placed in collections. Payment plans may be available and MUST be set up through our billing office. Please be aware that if your account is placed in collections, we may discharge you from our practice for non-payment; in such case, you will be notified by certified mail and allowed 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

RETURNED CHECKS: Should your check be returned for any reason you will be assessed a $50.00 returned check charge. All further balances will be payable with cash or credit/debit card ONLY.

FEES, COSTS, AND EXPENSES: You agree to be responsible for reasonable attorney's fees, court costs, and other collection expenses incurred by the practice if you do not pay for any of the charges as detailed in this Agreement.

Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

I have read and understand this Payment Agreement. I agree to abide by these terms.

_____ _____ _____

Signature of patient or responsible party **Print Name** **Date**

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: BOEV MEDICAL, PLLC

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.