Alliance Medical Group
WaterburyHEALTH

PATIENT INFORMATION FORM

Today's Date: ____________________
PCP: ______________________________
Hospital Preference: ______________
Pharmacy (Include Address & Phone Number): ________________________________

Demographic Information *(Please Print Clearly)*

❑Mr. ❑Mrs. ❑Miss ❑Ms.	Last Name:			Marital Status: *(circle one)* Single / Mar / Div / Sep / Wid
	First Name:	Middle Initial:		
Is this your legal name? ❑Yes ❑No	Former Name:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Email Address:

Street Address/City/Zip Code:

Home phone: ( ) Cell phone: ( ) Work phone: ( )

Job Title: ______________________________

Employer Name and Address: ______________________________

Employer phone No.: ( ) ______________________________

EMERGENCY CONTACT: Name: ______________________ Relationship: ______________

Phone(s): ______________________

How Were You Referred to Our Office? ______________________________

Insurance Information

Primary Insurance Co.	________	ID# ________	Group# ________	Co-Pay $________
Secondary Insurance Co.	________	ID# ________	Group# ________	Co-Pay $________

Subscriber (Insurance Holder's Name): ______________________ DOB: ______________

Insured's Employer Name, Address, & Phone Number: ______________________________

City/State: ______________ Zip Code: ______________ Relationship to Patient: ______________

Is this visit due to a work-related injury? ❑Yes ❑No

Workers Compensation Carrier Name: ______________________________

Are you seeing the doctor because of an accident? ❑Yes ❑No

Census Information

RACE	**Primary Race**	**Non-primary Race**
American Indian or Alaskan Native	❑	❑
Asian	❑	❑
Black or African American	❑	❑
Native Hawaiian or Other Pacific Islander	❑	❑
White	❑	❑
Other	❑	❑
Decline to answer	❑	❑

ETHNICITY: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Other ❑ Decline to answer

PREFERRED LANGUAGE:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicians of Alliance Medical Group ("AMG"). I understand that I am financially responsible for any balance, including my policy deductibles and co-insurances. These are required payments by my insurance company, not AMG. I authorize AMG or my insurance company to release any information required to process my claims.

Patient Print Name ______________ *Patient Signature* ______________ *Date* ______________

Legal Representative/Guardian Print Name ______________ *Legal Representative/Guardian Signature* ______________ *Date* ______________

PATIENT NAME:______________________DATE:____________

REASON FOR VISIT:______________________________

FAMILY HISTORY

	ALIVE/ DECEASED	HIGH BP	DIABETES	CANCER	ALLERGIES	ASTHMA	EMPHYSEMA	ECZEMA	HEART DISEASE	TB
FATHER										
MOTHER										
BROS/SIS										
BROS/SIS										
CHILDREN										
CHILDREN										

YEAR	HOSPITAL ADMISSION/REASON	YEAR	SURGERY

DATE AND PLACE OF LAST CHEST X-RAY______________

DRUG ALLERGIES:______________________

LAST TB SKIN TEST:________YR________**RESULTS: +/-**

HAVE YOU HAD A RECENT HIV TEST?________**RISK FACTOR: +/-**

ALCOHOL CONSUMPTION:__________**OZ. PER DAY**______**WK**______**YRS**

SMOKING:________**PACKS PER DAY**________**YEARS**

COFFEE/TEA:________**CUPS PER DAY**

MEDICAL HISTORY – CHECK ANY THAT APPLY

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Decreased Appetite
- ☐ Fatigue

EYES
- ☐ Visual Disturbance
- ☐ Discharge
- ☐ Redness
- ☐ Itchy Eyes

SKIN
- ☐ Rash
- ☐ Eczema
- ☐ Dryness
- ☐ Itching
- ☐ Hives

SLEEP
- ☐ Snoring
- ☐ Daytime fatigue
- ☐ Insomnia
- ☐ Restless legs

NEURO
- ☐ Headache
- ☐ Seizure
- ☐ Numbness
- ☐ Dizziness
- ☐ Unsteady Gait
- ☐ Memory Loss

ENT
- ☐ Nose Bleeds
- ☐ Nasal Congestion
- ☐ Post Nasal Drip
- ☐ Sinus Congestion
- ☐ Hoarseness
- ☐ Hearing Impairment
- ☐ Sore Throat

PSYCH
- ☐ Depression
- ☐ Anxiety
- ☐ Excessive Stress

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Weakness

HEART
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath lying flat
- ☐ Leg Swelling
- ☐ Pain in legs on exertion

LUNGS
- ☐ Shortness of breath
- ☐ Wheeze
- ☐ Cough
- ☐ Coughing up blood
- ☐ Chest Pain
- ☐ Chest Tightness

URINARY
- ☐ Pain w/urine
- ☐ Blood in urine
- ☐ Waking up to urinate
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Difficulty urinating

Heme
- ☐ Anemia
- ☐ Blood Clots
- ☐ Bleeding Problems
- ☐ Swollen Glands

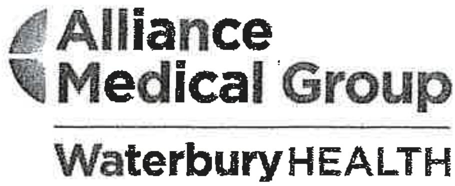
GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Heartburn
- ☐ Difficulty Swallowing
- ☐ Abnormal Pain

Endocrine
- ☐ Low Glucose
- ☐ High Glucose

MEDICATION LIST	
PATIENT NAME:	DATE OF BIRTH:

Today's Date:	Medications:	Problems/Diagnosis

The following information is very important to your health. Please take time to fully and completely fill out this information. We are counting on you.



HIPAA PRIVACY RESTRICTION QUESTIONNAIRE

Patient Name ______________________ Date of Birth ______________________
Home Phone ______________________ Cell Phone ______________________
Work Phone ______________________

Do you have an Advance Directive or Living Will? ❑ Yes ❑ No
(If yes, Please bring a copy to your next appointment.)

Where may we call you? ❑ Home ❑ Work ❑ Cell

Where can we leave you messages? ❑ Home ❑ Work ❑ Cell

May we send you reminder texts? ❑ Yes ❑ No

May we speak to your spouse or significant other regarding your treatment? ❑ Yes ❑ No

Name ________________ Relationship ________________ Phone Number ____________

May we speak to another family member regarding your treatment? ❑ Yes ❑ No

Name ________________ Relationship ________________ Phone Number ____________
Name ________________ Relationship ________________ Phone Number ____________
Name ________________ Relationship ________________ Phone Number ____________

______________________________ ______________________________
Signature of Person Granting Authorization Date

Relationship to Patient: ❑ ☐ Self ❑ Parent ❑ Guardian ❑ POA ❑ Other ________________

Pediatric Patients Only: ❑ Call Mother Only ❑ Call Father Only ❑ Call Either Parent
❑ Call Other: ________________

______________________ ______________________ ______________
Patient Print Name Patient Signature Date

______________________ ______________________ ______________
Legal Representative Print Name Legal Representative Signature Date

Relationship to Patient: ❑ Parent ❑ Legal Guardian ❑ Power of Attorney ❑ Other ____________

Alliance Medical Group
WaterburyHEALTH

PRESCRIPTION REFILL POLICY

All Alliance Medical Group providers (physician, nurse practitioner or physician assistant) participate in electronic prescribing directly to your local and mail order pharmacies. Our goal is to assist patients with prescription requests in an efficient manner. In order to process your request as quickly as possible, please see the details of our prescription policy.

- Prescription refills require close monitoring by your physician, nurse practitioner, or physician assistant to ensure the safe continuation of the appropriate dose, frequency and term of that medication. Your provider will prescribe the appropriate number of prescription refills to last you until your next scheduled appointment. 90-day supplies of medications will be provided based off provider discretion and insurance recommendations.

- It is the patient's responsibility to schedule your next appointment in advance and with adequate time to receive a prescription refill. **Patients are to be seen at least once every 3-6 months depending on your health history.**

- As prescriptions are prescribed with the amount of refills needed until the next appointment, almost all requests for prescription refills between regularly scheduled appointments will require an appointment in the office prior to authorization. The clinician will review the request from the pharmacy, as well as the patient's medical record, to determine appointment needs. The patient will be contacted by the staff to schedule such appointment, if necessary.

- In the event that you require an emergency refill, prescriptions refill requests should be electronically submitted from the pharmacy directly to the office. If approved by your provider, an appropriate refill will be submitted to your local pharmacy. If your prescription refill is not approved, please contact your provider's office to schedule an appointment.

- Patients requesting new prescriptions or antibiotics may be required to be seen for an appointment at the providers discretion.

- Maintaining current pharmacy information is the responsibility of the patient. Please confirm with our practice that your correct local pharmacy address and phone number or mail order pharmacy information is on file. Prescription refill requests will be submitted electronically to your pharmacy. Your local pharmacy will contact you when your prescription is ready.

- Our practice will always order generic prescriptions whenever available unless brand is medically necessary. Each insurance plan outlines a detailed classification for medications which could impact which medication, generic or brand, is prescribed and the cost to you. Contact your insurance plan for details.

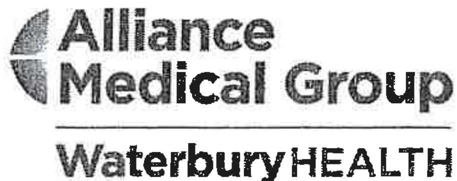
- Patients taking controlled substances must sign and adhere to our Controlled Substance Agreement

- ***Prescriptions classified as controlled substances are not processed after hours or on the weekends and require appointments to be maintained.***

- Our providers participate in the Connecticut Prescription monitoring program.

- **Please allow 48–72 hours to process prescription requests.** Medications requiring pre-authorization may require additional time to process. Please plan ahead for refills during holidays and when traveling.

Print Name ____________________ Signature ____________________ Date ____________________



PATIENT FINANCIAL RESPONSIBILITY STATEMENT

In order to for Alliance Medical Group ("AMG") to maintain our fees at the lowest possible rate, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to ask any questions you may have.

- You must pay any co-payment and applicable deductible amounts due at the time of service. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. There will be a $12.00 charge for all returned checks. Fee is subject to change without notice.
- If you are not insured, or if the services are not covered by your insurance, you are expected to provide full payment at the time services are rendered. AMG has income based financial assistance paperwork that will be given upon request.
- AMG will bill your insurance company as a courtesy. Please understand that the financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.
- In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. You will remain responsible for required co-payments, applicable deductibles and any services that are not covered by your insurance plan.
- If, by mistake, your health plan remits payment to you, please deposit the check from your insurance company and send a personal check to our billing company along with all paperwork received from your insurance company. Mail check and paperwork to.

Prospect Connecticut Medical Foundation

1801 W. Olympic Blvd File 2201

Pasadena, CA 91199-2201

- Your health plan may refuse payment of a claim for some of the following common reasons. This is not an all-inclusive list; please check with your insurance company should you have any questions.
  - This is a pre-existing illness that is not covered by your plan.
  - You have not met your full calendar year deductible.
  - The type of medical service required is not covered by your plan.
  - The health plan was not in effect at the time of service.
  - You have other insurance which must be filed first.
- Any patient who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time is considered a "no-show". A no-show patient may be charged $25.00, as set by the Practice, for failure to show. A patient, who is a no show three times, within a 12 month period, may be dismissed from the Practice. We ask that a 24 hour courtesy be given for all cancellations. A patient's appointment may be rescheduled if the patient arrives 15 minutes past their scheduled appointment time.

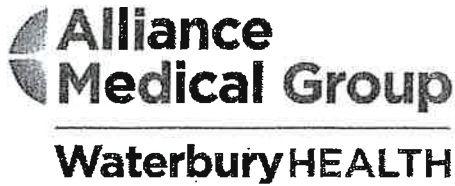
- Patient balances not paid after 90 days may be sent to a collection agency. Unpaid outstanding balances are subject to AMG's discharge policy.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

Patient Date of Birth *(MM/DD/YYYY)*: _____/_____/______

Patient Print Name	Patient Signature	Date
Legal Representative Print Name	Legal Representative Signature	Date

Relationship to Patient: ❑ Parent ❑ Legal Guardian ❑ Power of Attorney ❑ Other: ________________



Consent and Acknowledgment Form*

I consent to the use or disclosure of my protected health information by Alliance Medical Group to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Alliance Medical Group may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how my information will be used and disclosed can be found in the Notice of Privacy Practices. I understand that this consent is effective for as long as Alliance Medical Group maintains my protected health information.

Communication Consent- Phone Calls and Text Messages*

It is understood and agreed that Alliance Medical Group and/or its authorized agents may contact me, or a representative I appoint, using any contact or cell phone numbers I provide to it, or that may be available by any other means. I expressly agree that Alliance Medical Group may contact me at such numbers by telephone, pre-recorded voice messages and text messages, and may use an automatic telephone dialing system and/or an artificial pre-recorded voice.
This express authorization applies even if I am charged for the call under my mobile phone plan. I agree that such contact will not be "unsolicited" for purposes of local, state or federal law. I further agree that Alliance Medical Group and/or its authorized agents may monitor and/or record any communication with me.

By signing below, I understand and acknowledge the following:

- I have read and understand this Consent and
- I have received a copy of Waterbury Health's Joint Notice of Privacy Practices currently in effect.

Patient Print Name	Patient DOB	Patient Signature	Date

Legal Representative Print Name	Legal Representative Signature	Date

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: ____________

To Be Completed by AMG Workforce Member:

If unable to obtain written consent and acknowledgment:

☐ Individual refused ☐ Other ____________________

☐ Emergency treatment situation

☐ Individual not able to sign due to incompetence or other medical reason

Authorization to Disclose Health Information

PATIENT'S NAME			DATE OF BIRTH
ADDRESS			SOCIAL SECURITY NUMBER (last 4 digits only) XXX – XX -
CITY	STATE	ZIP CODE	PHONE NUMBER

☐ **RELEASE** Information from my medical record TO: ☐ **OBTAIN** Information FROM:

Office/Provider Name: ______________________________

Address: ______________________ City/State: ______________________

Zip: __________ Phone: ______________________ Fax: ______________________

2. Information to be disclosed / obtained: Dates of Service: ______________________
   - ☐ Complete Records
   - ☐ Medication Records
   - ☐ Pathology Reports
   - ☐ Hospital Reports
   - ☐ Progress Notes
   - ☐ Radiology reports
   - ☐ Psych/Drug/Alcohol/HIV
   - ☐ Laboratory tests
   - ☐ Entire record (Consideration will be given to releasing the entire record ONLY when subsections of the record will not serve the intended purpose of the disclosure.)
   - ☐ Other (please specify)

   ____

   ☐ Bills Dates of Service: ______________________

3. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.12.67, and/or HIV/AIDS – related information in accordance with CGS 19a-586(a), except as indicated below.

   ☐ No Mental Health ☐ No Substance Abuse treatment information ☐ No HIV/AIDS

4. I understand that I may have previously authorized the release of documents from other facilities that *may* ***include information related to AIDS, HIV infection, behavioral health services / psychiatric care, treatment for alcohol and/or drug abuse.***

5. Method of disclosure:
   ☐ Mail ☐ Fax ☐ Pick-up (Indicate contact number for when records are ready) ______________

   or name and relationship to patient of the individual authorized to pick up the record(s) being released from the facility:

   ____

6. I am requesting that this information be disclosed for the purpose of *(i.e. Legal reasons, continued care, insurance, another medical opinion, Worker's compensation, research, personal use, Social Security)*:

   ____

   ____

7. I understand this authorization may be revoked **in writing** at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here. **DATE OF EXPIRATION: ____________.**

8. I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying; not to exceed what is authorized by Connecticut State law.

9. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

10. I understand that Alliance Medical Group may not condition treatment on the provision of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through Waterbury Hospital. In such cases, specific authorization for the research-related treatment protocols / studies must be signed as a condition of participation.

11. I understand that my personal health information will be released in a paper format.

<u>Notice to Recipients:</u>
As the recipient of this information, you may use this information only for the stated purposes. You may disclose this information to another party ONLY:

- *With written authorization from the patient or his or her legal representative;*
- *As required or authorized by state and / or federal law; or*
- *If urgently needed for the patient's continued care.*

<u>If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply:</u>

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2 and Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

<u>Notice to Individual Requesting the Disclosure:</u>
Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

______________________________ ____________ ____________
Signature of Patient or Legal Representative | Date | Time

______________________________ ____________
Printed name of Legal Representative | Relationship to patient

______________________________ ____________
Signature of Individual Picking up Record | Relationship to patient

Please return this completed disclosure to:
Waterbury Pulmonary Associates
170 Grandview Ave., Suite 1, Waterbury, CT 06708
P: 203-759-3666
F: 203-759-3671