AZAR KORBEY, MD PLLC
WILLIAM FELDMANN, MD, PA
THERESA FELDMANN, MD
SAMANTHA KORBEY, APRN, FNP-BC
DANIELLE LEMAY, NP
19 & 22 Main St. – Salem, NH 03079
TEL:(603) 893-7905 FAX: (603) 898-6106

GENERAL INFORMATION

Name on Legal Documents* Last First Middle Initial | **Name you would like us to use:**

Sex on Legal Documents* ☐ Female ☐ Male
Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your name and pronouns are different from these, please let us know.

What are your pronouns? (e.g., he/him, she/her, they/them)

Date of Birth ***Month*** ***Day*** ***Year*** | **Social Security #**

Home Phone ( ) | **Cell Phone** ( ) | **Email:**

Street Address City State ZIP

Employer | **Work Phone** ( )

DEMOGRAPHIC INFORMATION: *This and all other parts of this form are subject to HIPAA compliance and will be kept confidential.*

Marital Status
- ☐ Married
- ☐ Partnered
- ☐ Single
- ☐ Divorced
- ☐ Other_____________

Veteran Status
- ☐ Veteran
- ☐ Not a Veteran

Language

Race

Ethnicity

Do you think of yourself as: (Check one)
- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Something else: _____________
- ☐ Don't know
- ☐ Choose not to disclose

What is your current gender identity? (Check one):
- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/ Female-to-Male (FTM)
- ☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)
- ☐ Nonbinary/Genderqueer/neither exclusively male nor female
- ☐ Additional gender category, please specify: ___________________
- ☐ Choose not to disclose

What sex were you assigned at birth? ☐ Female ☐ Male

INSURANCE INFORMATION

Primary Insurance

Address (Claims) City State ZIP

Insurance ID # | **Group #**

Subscriber's Name: | **Subscriber's Employer**

Subscriber's Date of Birth ***Month*** ***Day*** ***Year*** | **Subscriber's Social Security #:**

Patient's Relationship to Subscriber:

Secondary Insurance | **ID** | **Group #:**

Subscriber's Name: | **Subscriber's Date of Birth** *Month* *Day* *Year*

Patient's Relationship to Subscriber:

PERSON RESPONSIBLE FOR BILLS (Name)

Address (Claims) | **Phone** ( )

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize providers of Azar A. Korbey MD PLLC to release any medical or incidental information that may be necessary for medical care, or the processing of applications for financial benefits. I understand that I am financially responsible for any balance not covered by insurance.

Signature______________________________Date______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO NAMED PARTIES

If you are 18 years of age or older, no medical information will be released to a parent or guardian or significant other without your permission.

Do you give permission for information contained in your medical records to be released? YES ☐ NO ☐

NAME______________________________ RELATIONSHIP_______________ EMERGENCY CONTACT__________________________

NAME______________________________ RELATIONSHIP_______________PHONE #________________________________

I GIVE CONSENT FOR_____________________________TO ACCOMPANY ______________________TO DOCTOR VISITS.

SIGNATURE___________________________________

ALL CARE MEDICAL BILLING POLICIES:

POLICY ON PAST DUE ACCOUNTS:

It is the policy ofthis office that after 2 thirty day statements are sent to patient, billing dept sends a reminder letter and copy ofstatement; 14 days after that letter; a statement is sent to the patient with a notice "stamped for collection and fee applied, if sent to collections" . The patient is then given 7 days before we notify the collection agency; a call is also made to the patient to notify them that ifpayment is not received within 5 days, they will be sent to the collection agency and dismissed from the practice. Once the above time frame has expired, the billing dept. sends a certified letter and a regular letter to the patient. The collections agency is notified by fax. All payments must be made through the collection agency.

POLICY ON MISSED APPOINTMENTS:

It is the policy ofthis office, that ifa patient does not notify the office within 24 hours of their scheduled appointment, they will be charged for the missed appointment.

POLICY ON INSURANCE CARDS:

It is the policy ofthis office, that each time a patient is seen, they must show their insurance card. Ifthe patient does not have their card and we are unable to verify insurance coverage, they are to pay privately or reschedule their appointment. Ifa different primary care physicians name is on insurance card a waiver is to be signed by the patient, stating they will assume responsibility ifinsurance is denied.

______________________________ ____________________

Name **Date**

AZAR KORBEY, M.D. PLLC
WILLIAM FELDMANN, M.D., P.A.
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PATIENT HISTORY QUESTIONNAIRE

Name:____ Age:___________ Date:________________

Occupation:____ Company:____

1. Do you have or have you ever had any of the following? Please specify how long you've had it or when the problem occurred:

Diabetes____ Asthma____
High Blood Pressure____________________________________ Ulcers____
Heart Attack____ Anemia____
Heart Disease____ Epilepsy____
Tuberculosis ____ Cancer (Where?)______________________________________
Kidney trouble ____ Thyroid trouble_______________________________________
Other____

2. Please list medicines that you are allergic to and reaction that occurs:____
____
____

3. Please list foods that bother you in any way and the reaction that occurs:____
____
____

4. If you have hay fever, list what you are allergic to and which season (s) is worse:____
____

5. Please list the dates of all your immunizations, if you can remember (especially important to complete this section if a child):

Diphtheria, Tetanus, Pertussis_______________________________ Oral Polio Vaccine_________________________________
Measles, Mumps, Rubella___________________________________ Meningitis____
Tuberculosis Test____ Adult Tetanus Shot__________________________________

6. Do you smoke?__________________ How much per day?_________________ How many years?______________________
Are you a former smoker?_________ When did you quit?________ How many years?_______ How much?_______

7. How many cups of caffeinated beverages do you drink each day? __________________
8. How much alcohol do you drink each day? (Be honest)____________ If you used alcohol heavily in the past, when did you quit? _________
9. Do you eat a balanced diet? ____
10. Please list any operations you have had, what year was it done and the name of the surgeon:_____________________________________
____
11. List any hospitalizations besides surgery, including the year and the physician at the time:______________________________________
____
12. Are you: Single_______ Married/# of years_______ Widow(er)_______ Divorced_______ Significant Other_______

(Females only #'s 13-21)

13. How many pregnancies have you had (please include any miscarriages or abortions in this number):_____________________________
Out of this number, how many: Miscarriages? __________ Abortions? __________ Stillbirths? __________
14. Please give total number of living children: _________________
15. What date did your last period begin? _____________________
16. How old were you when you had your first period? _________________
17. Are your periods regular? _________ If yes, how many days apart are they and how long do they last? _____________________________
18. Do you get severe menstrual cramps? ___________ If yes when do they first start? ____
19. When was your last Pap test and who was the doctor that performed it?____
20. Have you ever had a Pap test that was abnormal?__________ If yes please indicate therapy given, if any: ___________________________
21. If you have gone through menopause ("the change of life"), approximately how many years ago? ___________________________________

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FAMILY HISTORY

22. List whether parents are living or deceased. Please give current age or age at time of death and cause of death:
    Mother ____ Father____
23. List first names and ages of all your children. Please indicate adopted or step-children if applicable:__________________________________
____
24. Please list name, age and cause of death of any deceased children:____
____
25. Please list number of living Brothers________ Sisters________
26. Please list number of deceased Brothers________ Sisters________
27. Please list any family member(s) that have ever had any of the following illnesses. Please be specific as to which side of the family (mother's or father's) and go back as far as your great- grandparents if you can. Remember to include uncles, aunts, cousins, nieces and nephews:
    Diabete:s____
    High Blood Pressure:____
    Heart Attack: ____
    Other Heart Disease:____
    Ulcers:____
    Asthma:____
    Epilepsy:____
    Cancer: ____
    Thyroid Trouble:____
    Other Illnesses:____

28. List Medicines that you take, the dosage and how often you take it:
    ____
    ____
    ____
    ____

REVIEW OF SYSTEMS

29. Please indicate if you have ever had or now have any problems with the following. Please try to be specific as to the nature of the problem, when it occurs, and what makes it better or worse:
    Eyes, Ears, Nose, Throat:____
    Chest Pain:____
    Shortness of Breath:____
    Constipation, Diarrhea:____
    Stomach Trouble:____
    Do you get a lot of indigestion?_______ If so, which foods seem to bother you the most? ____
    Urinary Trouble:____
    (Men) Problems with the penis or testicles, including difficulty with erections or ejaculation?___________________________________
    (Women) Vaginal infections, how often?____
    Urinary Tract Infections (how many times in the past and when was the last one)____
    Joint Pains (which joints)____
    Worse in Wet Weather?__________________________________ Worse in Cold Weather?_________________________________
    Do your legs ever swell up?___________ When?____
    Do you ever wake up from sleep short of breath?____
    How many pillows do you sleep on at night?_______ If more than one, is it for comfort or do you breathe easier?_________________
    Do you ever feel cold or hot when everyone else in the room is comfortable?____

Any other problems? ____
____
____
____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW ALL CARE MEDICAL MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

All Care Medical is required by law to maintain the privacy of your protected health information This information consists of all records related to your health, including demographic information, either created by All Care Medical or received by All Care Medical from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. All Care Medical will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.'

All Care Medical reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

<u>Uses and Disclosures of Your Protected Health Information not Requiring Your Consent</u>

All Care Medical may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

<u>Treatment</u> may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;

For example, All Care Medical may share or transfer your healthcare information with your referring physician, primary care doctor or other health care provider.

<u>Payment activities</u> may include:

- Activities undertaken by All Care Medical to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, All Care Medical will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

<u>Healthcare operations</u> may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, All Care Medical may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

All Care Medical may contact you, by telephone or mail, to provide appointment reminders.You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when All Care Medical is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly

This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of

an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

All Care Medical will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that All Care Medical has taken action in reliance thereon. Any revocation must be in writing.

<u>Your Rights Regarding Your Protected Health Information</u>

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by All Care Medical to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. All Care Medical may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that All Care Medical send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that All Care Medical not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that All Care Medical amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by All Care Medical for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

*It is the policy of All Care Medical that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

Any person or patient may file a complaint with All Care Medical and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated.To file a complaint with All Care Medical, please contact the Privacy Officer at the following:

Privacy Officer
All Care Medical
22 Main Street
Salem, NH 03079

Name: ____ Date: ___________

ALL CARE MEDICAL
22 MAIN STREET
SALEM, NEW HAMPSHIRE 03079
TEL: (603)893-7905   FAX: (603)898-6106

WAIVER OF LIABILITY

I HAVE BEEN NOTIFIED THAT MY INSURANCE COMPANY MAY NOT COVER THIS DATE OF SERVICE AS I HAVE NOT NOTIFIED THEM OF MY SELECTION OF A NEW PRIMARY CARE PHYSICIAN.

OR

I HAVE NOT SHOWN MY INSURANCE CARD DURING MY VISIT.
IF MY INSURANCE COMPANY DENIES THESE CHARGES, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

OR

MY INSURANCE COMES UP ACTIVE. HOWEVER, NO PRIMARY CARE PHYSICIAN IS SHOWING UP ON THE WEB SITE. I WILL FOLLOW UP WITH MY INSURANCE ON THIS MATTER TO MAKE SURE THAT MY DOCTOR IS LISTED AS PCP FOR BILLING PURPOSES

OR

I HAVE BEEN NOTIFIED THAT AN AUTHORIZATION FROM MY PRIMARY CARE PHYSICIAN MAY BE NEEDED FOR SERVICES PROVIDED TODAY. IF AN AUTHORIZATION IS NOT OBTAINED FROM MY PRIMARY CARE PHYSICIAN, OR IF MY INSURANCE COMPANY DENIES THESE CHARGES, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

OR

I HAVE PRESENTED MY INSURANCE CARD, BUT THE OFFICE IS UNABLE TO PULL UP ELIGIBILITY. I WILL SIGN A WAIVER BECAUSE I KNOW MY INSURANCE IS ACTIVE AND I WILL BE RESPONSIBLE FOR PAYMENT.

OR

I AM AWARE THAT I AM RESPONSIBLE FOR ANY SERVICES NOT COVERED BY MY INSURANCE COMPANY.

OR

I AM AWARE THAT THIS OFFICE DOES NOT ACCEPT ANY MEDICAID PRODUCTS. THEREFORE, I WILL BE RESPONSIBLE FOR ALL BALANCES

PRINT NAME:

_________________________________   ________________

Our physicians make every effort to utilize local hospital and consulting doctors when needed. This assures that we will get your records and consults as quickly as possible. If you request to be sent to a hospital or doctor outside of the Merrimack Valley, it is your responsibility to make sure that they are covered by your insurance and also that a copy of all records be sent to us. In these cases, the medical records may not always be available in a timely manner. Thank you.

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