INTERNAL MEDICINE ASSOCIATES LLC

Patient Information

Please review the following information and initial below confirming that ALL information is correct.

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ SSN: _____ Gender: _____

Address: _____ City, State, Zip: _____

Marital Status: _____ Employment Status: _____ Employer: _____

Referring Provider: _____ Primary Care Provider: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Preferred Contact: ☐ Home ☐ Cell ☐ Work

Work Phone _____ Preferred Reminder Calls: ☐ Call ☐ Text ☐ Email

Initial: _____

Insurance

Please complete the below section OR provide the front office with your insurance card.

Company: _____ ID: _____ Group #: _____

Subscriber: _____ Relationship to Patient: _____ DOB: _____

Company: _____ ID: _____ Group #: _____

Subscriber: _____ Relationship to Patient: _____ DOB: _____

Initial: _____

Emergency Contact or Parent/Legal Guardian

Name: _____ Name: _____

Patient Relationship to Contact: _____ Patient Relationship to Contact: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

If this patient is over 18, do they have a legal guardian, conservator, or power of attorney? If yes, a copy of the related paperwork MUST be provided. ☐ No ☐ Yes

I hereby authorize Internal Medicine Associates to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize Internal Medicine Associates to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

X _____ Date: _____

Patient or Legal Patient or Legal Representative Signature

Employee Initials: _____

Acknowledgement of Patient Financial Responsibility

All patients are required to complete provided forms as determined by Internal Medicine Associates, LLC. No provider-patient relationship is established until forms are completed and the provider has personally evaluated the patient. Refusal to complete certain forms is a basis for the provider to decline evaluation of a prospective patient.

- Internal Medicine Associates, LLC bills your insurance. In order to verify your plan, you must provide current insurance information and valid government issued photo identification.
- It is not possible for Internal Medicine Associates to know the specific benefits of your plan. **It is your responsibility to be aware of your coverage and to ensure that your bill is paid.**
- **It is your responsibility to verify coverage and benefits with your insurance company prior to an evaluation, testing, or procedure. This may include getting authorization by your insurance company before the service, if that is required under your plan.** In many instances, your provider may order testing independent from Internal Medicine Associates. Such organizations can include laboratories, imaging facilities, outpatient procedure centers and hospitals. These facilities and related professionals will bill you and your insurance for their services. Our office will provide them with your billing information, but is not responsible for the administration or billing of those services.
- **Payment of deductible**: if not already met, the portion of charges that the patient is responsible for, is required **at the time of service**. Payment can be made by cash, check, or credit card. Payments are accepted in office, by telephone or online via our secure payment portal www.internalmedak.com. If you need to make other financial arrangements, please ask for an account representative.
- **Your insurance company** may pay on charges according to their **usual and customary fee scale**. In the event your insurance company determines a service is "not covered" or above the "usual or customary charges", you will be responsible for the balance due.
- **Cancellation Policy/ Fee Scale**: In order to manage provider availability, if you need to cancel or reschedule, it is your responsibility to notify Internal Medicine Associates **prior to your appointment/procedure. Failure to do so, failure to show for appointment/procedure or failure to show up on time may result in the following charges as noted in the below fee table, for which you are personally responsible:**

Office Visits	**Procedures***
Locations: Internal Medicine Associates, Anchorage and Internal Medicine Associates, Wasilla	Locations: Anchorage Endoscopy Center, Alaska Regional Hospital, or Providence Hospital
*Must be cancelled with at least 24 hours' notice to avoid incurring a **$50.00 no show/late cancel fee.***	*Must be cancelled with at least 48 hours' notice to avoid incurring a **$250.00 no show/late cancel fee.***
COVID-19 PROCEDURE TESTING	
Per the State of Alaska COVID-19 Health Mandate 15, patients are required to have a COVID-19 test prior to their procedure. Failure to do so at the designated testing facility within the timeframe advised upon scheduling may result in a **$50.00 no show fee**, as this would require a preventable last minute appointment cancellation.	

**Other facilities may have separate no show/late cancel fees.*

- **I acknowledge and agree that I have been offered a copy of Internal Medicine Associates Notice of Privacy Practices.**
- **I acknowledge and agree to all financial responsibilities as outlined in this agreement.**
- **I authorize Internal Medicine Associates, LLC to bill my insurance and release medical or other information necessary to process my medical claims. I request payment of government or other insurance benefits to Internal Medicine Associates, LLC.**

Patient Signature Date

Printed Name of Patient DOB

Authorization to Use and/or Disclose Health Information

(REQUEST FOR RELEASE OF MEDICAL RECORDS)

I, _____ , date of birth _____ , authorize Internal Medicine Associates, LLC. to use and/or disclose my health information to: **Myself** and/or _____

(please print full name)

I authorize disclosure of the following types of health information

Types of Health Information *If not checked, default is ALL TYPES*	**Date(s) of Service for requested records:** *If left blank, default is ALL DATES*	**For the following purpose(s):** *If not checked, default is CONTINUATION OF CARE*
☐ Office/Provider Notes	_____	☐ Continuation of Care
☐ Laboratory Reports	_____	☐ Personal Request
☐ Pathology and Biopsy Reports	_____	☐ Insurance Claims
☐ Imaging Studies	_____	☐ Legal Request
☐ Billing Statements	_____	☐ Other: _____
☐ Other: _____	_____	

The following items must be <u>initialed</u> to be included in the use or disclosure of other health information:

_____ HIV/HCV/AIDS / SEXUALLY TRANSMITTED related health information and/or records

_____ Mental health information and/or records

_____ Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information): _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Practice Manager or the Privacy Officer. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand I have a right to obtain a copy of this Authorization, upon requesting. I understand that this form does not supersede any previously signed Release of Information.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

This release is effective for one year after the date of signature or until _____ (date or event).

_____

Patient or Legal Guardian Signature Date

_____

Printed Name of Legal Representative Relationship of Legal Representative to Individual

INTERNAL MEDICINE ASSOCIATES LLC

Code of Conduct

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Internal Medicine Associates expects *patients, and accompanying family members and visitors* to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff. The code of conduct is not representative of past or present events or behaviors.

The following behaviors are prohibited:

- Possession of firearms or any type of weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects
- Intentionally damaging equipment or property
- Climbing on furniture
- Making verbal threats to harm another individual or destroy property
- Unwelcomed sexual comments or advances
- Making menacing comments or gestures
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality

Violators are subject to removal from the facility and/or discharge from the practice. Management reserves the right to include behaviors and actions not listed above that are deemed disruptive or threaten the rights or safety of other patients and staff.

If you are subjected to any of these behaviors or witness inappropriate behavior, please immediately report to any staff member.

Patient Signature Date

Printed Name of Patient or Legal Representative Relationship of Legal Representative to Individual

Internal Medicine Associates, LLC
Acknowledgement of Prohibition on Photography, Videography & Other Recordings

I understand that while I am receiving services at Internal Medicine Associates, LLC (IMA), I am required to comply with the following rules and restrictions with regard to photography, videography and other recordings:

- Patients, family members and visitors are not permitted to take photographs of, or audio or video recordings of patient visits, medical equipment or patient records. If patient records are requested, a copy will be provided in accordance with IMA policy.
- Individuals are also not permitted to photograph or record others in the IMA facilities.
- Written consent of all individuals involved is required for any variance from these rules.
- If staff becomes aware of any attempt to photograph or record in violation of these rules, staff may take reasonable steps to stop the activity, including a call to security.
- I understand that the penalties for violating one of the above requirements are at the reasonable discretion of my provider and may include termination of services.

I agree to follow the rules outlined above, and will not photograph or record anything while I am receiving services at Internal Medicine Associates, LLC.

Print Full Name (first, middle initial, last): **Signature:**

Date Signed:

Health and History

Date: _____ Patient Name: _____ DOB: _____

Gender: _____ Age: _____ Occupation: _____

Referring Provider: _____ Primary Care Provider: _____

Chief Complaint/Reason for Visit: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Medications & Vitamins (Prescription and/or Over the Counter)

Name:	Dose:	Times/day:	Prescribed By:

Allergies

Name:	Reaction:

Surgery	Year

Hospitalization	Year

Social History

Do you currently use tobacco? ☐ Yes ☐ No Have you ever used tobacco? ☐ Yes ☐ No

per day: ___ Cigarettes ___ Cigars ___ Chewing How many years have/did you use tobacco? _____

Do you drink alcohol? ☐ Yes ☐ No # per week of: ___ Beer ___ Wine ___ Liquor

Do you drink caffeine? ☐ Yes ☐ No # per day of: ___ Coffee ___ Tea ___ Cola

Do you use recreational or IV drug use? ☐ Yes ☐ No How many/what kind of pets? _____

Family History

☐ Heart disease – Relative: _____ ☐ Cancer – Relative: _____

☐ Hypertension – Relative: _____ ☐ Asthma – Relative: _____

☐ Emphysema – Relative: _____ ☐ Colitis – Relative: _____

☐ Colon polyps – Relative: _____ ☐ Colon cancer – Relative:_____

☐ Gallbladder disease – Relative: _____ ☐ Hepatitis – Relative: _____

☐ Diabetes – Relative: _____ ☐ Depression – Relative: _____

☐ Sleep apnea – Relative: _____ ☐ Other – Relative: _____

Relative	Age	Illness	Deceased
Father	_____	_____	☐Yes ☐No
Mother	_____	_____	☐Yes ☐No
Sibling	_____	_____	☐Yes ☐No
Child	_____	_____	☐Yes ☐No
Grandfather	_____	_____	☐Yes ☐No
Grandmother	_____	_____	☐Yes ☐No

Patient Name: _____ **DOB:** _____

Systemic

Review of Systems:

☐ Fatigue
☐ Fever
☐ Chills
☐ Change in weight
☐ Night sweats

ENT

Past Medical History:

☐ Glaucoma
☐ Hearing loss

Review of Systems:

☐ Headache
☐ Sinus pressure
☐ Neck pain/stiffness
☐ Neck swelling/lump
☐ Vision problems
☐ Eye itching/pain
☐ Ear ache
☐ Nasal discharge/blockage
☐ Hoarseness
☐ Sore throat
☐ Bleeding gums
☐ Mouth sores

Cardiovascular

Past Medical History:

☐ High blood pressure
☐ High cholesterol
☐ Heart attack
☐ Heart murmur
☐ Prolapsing Mitral Valve
☐ CAD
☐ On blood thinners
☐ Blood clots
☐ Angina

Review of Systems:

☐ Chest pain
☐ Palpitations

Pulmonary

Past Medical History:

☐ Asthma
☐ Bronchitis
☐ History of TB
☐ Use of BCG vaccine
☐ Emphysema
☐ COPD
☐ Apnea
☐ Abnormal chest X-ray/chest CT
Date/Location:_____

Pulmonary - continued

Review of Systems:

☐ Cough
☐ Wheezing
☐ Shortness of breath
☐ Snoring
☐ Excessive daytime sleepiness
☐ Chest pain w/ deep breathing
☐ Chest pain w/ rotating torso

Gastrointestinal

Past Medical History:

☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Esophageal Reflux
☐ Hepatitis
☐ Gallbladder Disease/Gallstones
☐ Colon cancer
☐ Intestinal Polyps removed
Date: _____

Review of Systems:

☐ Appetite changes
☐ Difficulty swallowing
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Bloody or black stools
☐ Uncontrollable gas/bloating

Genitourinary

Past Medical History:

☐ Urinary tract infection (UTI)
☐ Kidney stones
☐ Are you pregnant?
Date of last period: _____

Review of Systems:

☐ Blood in urine
☐ Burning during urination
☐ Increased urinary frequency

Musculoskeletal/Rheumatology

Review of Systems:

☐ Joint pain/stiffness
☐ Joint swelling
☐ Back pain
☐ Muscle aches or weakness
☐ Scleroderma
☐ Other: _____

Neurological

Review of Systems:

☐ Dizziness
☐ Fainting
☐ Numbness
☐ Sensory disturbances
☐ Stroke
☐ Seizure disorder

Endocrine

Past Medical History:

☐ Thyroid disease
☐ Thyroid cancer
☐ Adrenal tumor
☐ Pituitary tumor
☐ Parathyroid disease
☐ Osteoporosis
☐ Diabetes
☐ Gestational diabetes

Review of Systems:

☐ Heat or cold intolerance
☐ Excessive thirst or urination
☐ Excessive sweating
☐ Change in libido (sex drive)
☐ Change in shoe or ring size
☐ Stretch marks
☐ Facial hair growth (women)

Psychological

Past Medical History:

☐ Anxiety
☐ Depression

Review of Systems:

☐ Sleep disturbances
☐ Confusion
☐ Memory lapse or loss
☐ Other: _____

Skin

Past Medical History:

☐ Eczema
☐ Psoriasis

Review of Systems:

☐ Itching
☐ Skin lesions
☐ Rashes

Hematologic

Past Medical History:

☐ Anemia
☐ Easy bleeding

Other

☐ HIV-1 infection

Patient or Legal Representative Signature Date

Physician Signature Date