PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Last Name	First Name	Date of Birth	Gender Male Female	Age
Patient's preferred name/nickname		Marital Status (please circle) Single Married Divorced Widowed		
Patient's Social Security Number		E-mail Address		
Home Address		City	State	Zip
Mailing Address if Different		City	State	Zip
Home Telephone Number		Best Phone Number to Call (cell phone, pager, work etc.)		
Occupation		Work Phone Number		
Spouse's Name (if applicable)				
Name(s) of Your Other Physician(s)				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address		City	State	Zip
Home Telephone		Best Phone Number to Call (cell phone, pager, work etc.)		
Nearest Relative (even if not living with your)				
Home Telephone		Best Phone Number to Call (cell phone, pager, work etc.)		
INSURANCE INFORMATION – IF YOU HAVE HEALTH INSURANCE				
Subscriber's Name		Relationship to Patient		
Subscriber's Date of Birth		Subscriber's SSN#.		
Insurance Company	Insurance ID Number	Insurance Group Number		
Employer Name				
ADDITIONAL INFORMATION				
Local Pharmacy: Name		Address	Phone Number	
Mail-in Pharmacy: Name Pharmacy ID Number:		Address	Phone Number	
Do you have: **DNR Order** Yes No	**PowerOfAttorney** Yes No	**Living Will** Yes No		
If yes to any of the above, please provide us with a copy.				

FINANCIAL POLICY

BASIC POLICY Pay for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. **Copayments and deductibles are due at the time of service.** Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. **If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.**
MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you.
All copayments or deductibles are due and payable at the time service is provided.
NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
WORKER'S COMPENSATION If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.
YEARLY HEALTH CHECKS Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.
MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24-hour notice to cancel appointments. We may charge you for missed appointments or, for repeat occurrences, you may be dismissed from the practice.

Please check on: I have paid my insurance deductible for the calendar year ________ ☐ Yes ☐ No ☐ Don't know

I have read, understood, and agreed to the above financial policy for payment of professional fees.
I understand that I am ultimately responsible for all professional fees.

Signature: ______________________________ Date: ____________________

PATIENTS WITH INSURANCES – PLEASE READ AND SIGN BELOW:

ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **First Internal Medicine, Prof. LLC – Dr. Igor Huzicka**.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: ______________________________ Date: ____________________

MEDICARE PATIENTS – PLEASE READ AND SIGN BELOW:

SIGNATURE ON FILE. I request payment of authorized Medicare benefits be made either to me or on my behalf to **First Internal Medicine, Prof. LLC – Dr. Igor Huzicka**, for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print):	**PROVIDER**
Patient's Signature:	First Internal Medicine, Prof. LLC
Patient's Medicare No.: Date:	

First Internal Medicine, Prof. LLC
Comprehensive medical care for adults
Igor Huzicka, MD & Tamara Murphy, PA-C

PROTECTING YOUR PRIVACY – WHOM AND HOW WE MAY CONTACT

1) If we cannot speak with you in person, do we have permission to leave phone messages regarding your medical care at the following numbers?
   a. Your home phone _____
   b. Your cell phone _____
   c. Your work phone _____

2) Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care questions):

   ____

   ____

3) Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name: _____________________________ Phone: ____________________

   Name: _____________________________ Phone: ____________________

4) If you would like to receive appointment reminders and other communication by email*, please write your email address:

   ____

   * I understand that confidentiality of information sent via e-mail cannot be guaranteed. I also understand that I should not use e-mail to communicate with Dr. Huzicka in an emergency situation.

5) Would you like to communicate with our office, schedule appointments, view and edit your medical information through a patient portal on our office website?

   YES: ________ NO: ________

PRINT PATIENT NAME: ________________________________ Date_____________

SIGNATURE: _______________________________________

Office Copy – Please read and sign at the bottom

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **First Internal Medicine, Prof. LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. I have been provided with a copy of the Notice of Privacy Practices at the time of signing of this consent. **First Internal Medicine, Prof. LLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Dr. Igor Huzicka, **First Internal Medicine, Prof. LLC**
4950 S Yosemite St, Suite F2 PMB 346, Greenwood Village, CO 80111

With this consent, **First Internal Medicine, Prof. LLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **First Internal Medicine, Prof. LLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **First Internal Medicine, Prof. LLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **First Internal Medicine, Prof. LLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **First Internal Medicine, Prof. LLC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **First Internal Medicine, Prof. LLC** may decline to provide treatment to me.

____
Signature of Patient (or Legal Guardian)

______________________________ ____________________
Print Patient's Name (or Legal Guardian, if applicable) Date