ROZIN Internal Medicine

Spencer I. Rozin, MD FACP
721 Wellness Way, Suite 220
Lawrenceville, GA 30046

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

Important: Do not sign this form without reading and understanding its contents.

I hereby apply for and consent to treatment by this Practice and its Medical Staff, and authorize all routine Practice activities, treatments, examinations and diagnostic services. During the course of my care and treatment, I understand that various types of tests, and diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, medical assistants, physician assistants, or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks,** such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, pain, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments, and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, pain, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition, and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically, by injection, or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, pain, perforation, puncture, infection, nerve damage, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Obtaining Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, pain, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function or death. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) **Insertion of Internal Tubes** such as bladder catheterizations and enemas, or ear lavages. The material risks associated with these types of Procedures include, but are not limited to, pain, internal injuries, bleeding, bladder or urethral perforation, infection, allergic reaction, loss of

bladder control and/or difficulty urinating after catheter removal, and possible perforation of the eardrum during ear lavage. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

(6) If provided a hot beverage (coffee, tea, water) by the Practice or staff, I understand these beverages are very hot and I assume the risk for any injury that may occur by consumption of or spilling of such beverages.

Consent for Treatment

I (We), the undersigned, have read and fully understand the Consent for Treatment above. My signature acknowledges that I have been given the opportunity to satisfy myself by asking questions about the Consent for Treatment. I voluntarily give my consent to any and all Healthcare Professionals at the Practice for Practice care. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this medical practice. This consent will remain valid indefinitely, unless revoked in writing by me and delivered to the Office Manager of the practice.

Signed: ______________________________________ ______________________

Patient/Patient's Representative Date

__________________________ ____________________ ________________

Relationship if Other than Self Witness Date

ROZIN Internal Medicine

Patient Information

Name: ______________________________

Name you like to be called? ________________

Who Referred You: ____________________

Sex: □Male □Female Date of Birth: ___/___/_____

Social Security #: _____-_____-__________

Street Address: ________________________

City: _______________ State: _____ Zip: ________

Home Phone: __________________________

Cell Phone: ____________________________

E-mail Address: _________________________

□Single □Married □Separated □Divorced

Spouse Name: __________________________

Spouse Cell Phone: _______________________

Spouse Work Phone: ______________________

Spouse E-mail Address: ___________________

Patient Employment

□Employed □Unemployed □Retired □Student

Employer: ______________________________

Occupation: ____________________________

Work Phone: ____________________________

Business Address: ________________________

____

Emergency Contact

Name: _________________________________

Relationship: ___________________________

Home Phone: ___________________________

Cell Phone: ____________________________

Work Phone: ____________________________

Guarantor (Who is Responsible for This Account)

□Patient □Other

Name: ______________________________

Relationship to Patient: __________________

Street Address: ______________________________ City: ______________ State: _____ Zip: ________

DOB: ___/___/______ SSN# ____-_____-_______

Primary Insurance Information

Do you have Medicare? □Yes □No

Insurance Co. Name: _______________________ Policy ID #: __________________________

Phone #: _____________________________ Group #: ____________________________

Street Address: ______________________________ City: ______________ State: _____ Zip: ________

Secondary Insurance Information

Insurance Co. Name: _______________________ Policy ID #: __________________________

Phone #: _____________________________ Group #: ____________________________

Street Address: ______________________________ City: ______________ State: _____ Zip: ________

Insurance Authorization and Assignment

I hereby authorize Spencer Rozin, M.D. and/or ROZIN Internal Medicine to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. I acknowledge this authorization for assignment of benefits will continue indefinitely unless revoked in writing by me. I will be responsible for all collection fees incurred if an outside collection agency is used to recover past due balances. I have read, understand and agree to the Payment Policies of ROZIN Internal Medicine.

________________________________ ______________ ______________

Signature Relationship Date

ROZIN Internal Medicine
Spencer I. Rozin, MD FACP
721 Wellness Way, Suite 220
Lawrenceville, GA 30046

Office (770) 709-0900 **Fax (770) 709-7444**

Authorization for use of Email for Communicating Protected Health Information (PHI)

I authorize ROZIN Internal Medicine to use standard email to communicate with me regarding my Protected Health Information (PHI). I understand that email is a non-secure means of communication and I understand that email is not compliant with HIPPA (Health Insurance Portability and Accountability Act of 1996). **I understand that email is not appropriate for urgent or emergency situations**. I acknowledge that I am responsible to follow up with a telephone call to ROZIN Internal Medicine if I do not receive a response to an email within 72 hours. I recognize that email communications may become part of my permanent medical record.

This consent will remain valid indefinitely unless revoked in writing. I may cancel this consent in writing at any time by doing the following: writing, signing, and dating a letter to the Privacy Officer at ROZIN Internal Medicine. This letter must include the patient's name, address, social security number, e-mail address and birth date. If I write a letter, it must say that I want to revoke my consent to authorize the use of email communication. I understand that information released prior to my canceling my consent is not covered by this cancellation.

I agree that it is my responsibility to inform ROZIN Internal Medicine of any changes to the authorized email address or if at any time I choose to cease using email as a means of communicating with the practice. I understand that should I initiate an email exchange between myself and ROZIN Internal Medicine from another email address, ROZIN Internal Medicine will be authorized to use that email address for communicating PHI as well. I have been informed of and understand the risks and procedures involved in using email. I agree to the terms listed on this form and consent to and authorize the use of email as one form of communication with ROZIN Internal Medicine.

____
Patient Email Address for Communicating PHI

____
Print Patient Name

____________________________________ ____________
Patient or legally authorized individual signature Date

ROZIN Internal Medicine

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of ROZIN Internal Medicine Privacy Practices

Patient's Name: ________________________________ Date of Birth: ____________

SSN: ________________________ Previous Name: ________________________

I understand that a patient's health information is private and confidential. I understand that ROZIN Internal Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Rozin Internal Medicine may use and disclose my personal health care information for filing insurance claims or to other treating physicians for continuity of care. In general, there will be no other uses or disclosures of the information. I understand that sometimes the law may require the release of information without my permission. These situations are very unusual. Examples would be if a patient threatened to hurt someone or the legally required reporting of certain diseases.

ROZIN Internal Medicine has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. ROZIN Internal Medicine may update this "Notice of Privacy Practices" at any time and without notice to me. A copy of the revised "Notice of Privacy Practices" may be requested in writing addressed to the Privacy Officer at the office of ROZIN Internal Medicine.

With this consent, ROZIN Internal Medicine may call my home or other alternative location and leave a message on voice mail, answering machine or in person in reference to any items that assist the practice in carrying out treatment, payment or health care operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including, but not limited to, laboratory or other test results. With this consent, ROZIN Internal Medicine may mail to my home or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements.

Under the terms of this consent, I can ask ROZIN Internal Medicine to limit how my personal health information is used or disclosed to carry out TPO. I understand that ROZIN Internal Medicine does not have to agree to my request. If ROZIN Internal Medicine does agree to my request, I understand that ROZIN Internal Medicine would try to follow the agreed upon limits. Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentially rights. These rights include, but are not limited to, access to my records, restrictions on certain uses, and receiving an accounting of disclosures as required by law.

ROZIN Internal Medicine has established procedures that help them meet their obligations to patients. These may include other signature requirements, written acknowledgements and authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs, etc. I will assist ROZIN Internal Medicine by following these procedures if I choose to exercise my rights described in the "Notice of Privacy Practices".

I may cancel this consent in writing at any time by doing the following: writing, signing, and dating a letter to the Privacy Officer at ROZIN Internal Medicine. This letter must include the patient's name, address, social security number, and birth date. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations. I understand that information released prior to my canceling my consent is not covered by this cancellation. If I do not sign this consent, or later revoke this consent, IMS does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of ROZIN Internal Medicine "Notice of Privacy Practices". My signature means that I agree to allow ROZIN Internal Medicine to use and disclose my personal health information to carry out treatment, payment, and health care operations and for other disclosures as outlined in the "Notice of Privacy Practices".

____
Print Name

______________________________ ____________ ____________
Patient or legally authorized individual signature Date Time

ROZIN Internal Medicine

PAYMENT POLICIES EFFECTIVE January 1, 2012

If you are not covered by any health insurance plan or this practice is not a participating provider with your health plan, full payment of all office visit and other service(s) charges is expected at the time services are provided. If you have insurance with which Dr. Rozin does not participate, Dr. Rozin will not file claims to these carriers. Under such circumstances, you will be responsible for an office visit charge based on the services provided. A $35.00 charge may be billed to any patient who does not pay these charges at the time of service. If you are hospitalized with Dr. Rozin actively engaged in your care, you will be responsible for a daily hospital visit charge of $125. You agree to be personally financially responsible for all these charges.

Charges for all covered medical services, not including services provided as part of your concierge services, are the responsibility of the patient. We will file insurance claims only for patients with Medicare coverage or if we are "in network" with your plan and if we have a current copy of the patient's insurance card on file. However, ultimately, the patient is responsible for the payment of all charges. It is the policy of our practice to collect all fees, co-payments, co-insurance, non-covered services charges and deductibles as required by your insurance at the time of service. A $35.00 charge may be billed to any patient who does not pay these charges at the time of service and you agree to be personally financially responsible for all these charges.

Certain tests or procedures we perform are considered screening, not medically necessary or experimental by some insurance companies and Medicare. ROZIN Internal Medicine may not know at the time of your visit if your insurance company will pay for all services and you may not be notified that a service is not covered at the time of your visit. If your insurance company does not pay for these services, excluding those services provided as part of your concierge services, you accept responsibility for full payment of these charges. Charges for certain screening procedures must be paid for by you prior to having the service provided.

The State of Georgia mandates that insurance companies pay for undisputed claims within 30 days of submission. If we are an "in network" provider with your insurance company, we allow 35 days for your insurance to pay a claim. If your insurance company has not paid in full by this time, you will be responsible for all outstanding charges. Please follow up with your insurance company to make sure they pay your claims. We will refund any overpaid amount to the patient or insurance company as appropriate.

We rely on the insurance information you give us in filing insurance claims for you. Many insurance plans require us to obtain pre-approval for certain procedures before they will pay for them. If we do not have accurate information about your insurance coverage, we cannot obtain pre-approval for a service and you may then be responsible for all charges not pre-approved. Also, many insurance plans have a "Timely Filing Requirement" which limits how long after a service is performed that we can file a claim. If we do not have correct insurance information, we may not be able to file your claim before the "timely filing" period ends. If the insurance information that you provide us is not accurate, you will be liable for the full amount of all charges and agree to pay these charges in full.

Patients who do not show up for a confirmed appointment, or who cancel with less than 24 hours notice, may be billed and agree to be responsible for full payment of a $50.00 charge. If you do not show up for an appointment for a treadmill stress test, you will be charged and agree to be responsible for full payment of a $100.00 charge. If you do not show up for a Nutritional Consultation you will be billed and agree to be responsible for full payment of a $65.00 charge. If you do not show up for a Physiologic Assessment appointment you will be billed and agree to be responsible for full payment of a $75.00 charge.

Account Credits – If you or your spouse has a credit on their account, you authorize ROZIN Internal Medicine to use that credit at any time toward payment of any amounts owed on either account.

Delinquent Accounts – Once we have exhausted our internal efforts to obtain payment for service, we will refer accounts to an outside collection agency. These agencies report delinquent accounts to credit reporting services. You will be charged and agree to pay a $50.00 fee and for all collection and/or attorneys fees that we incur trying to collect on your account. If we must take you to court for non-payment, you agree to pay for all court costs and attorney fees associated with collecting these owed fees.

Returned checks – Occasionally, a check written to us is returned unpaid. When this happens, we will contact the patient. Returned checks must be paid in full within 10 days of notification plus a $40.00 fee. We will pursue all legal means to collect on returned checks and you will be responsible for all fees associated with these collection efforts.

Medical records fee – I understand that federal and state laws allow for a fee to be charged for copying of patient records and I will be personally responsible for the payment of such fees. Fee payment may be requested prior to release of requested records.

Annual fee payment for the ROZIN Internal Medicine concierge care program is due on enrollment and may be made by credit card or check made payable to ROZIN Internal Medicine. Semiannual payments are by credit card only, 60% upon enrollment and 40% due six (6) months after Effective Date. You must pre-authorize a credit card charge for the second payment at time of enrollment in the Program. If paying by credit card, 3% of charged amount will be added per credit card transaction. This option is available only to patients joining in January of each year. Patients joining after January must pay the annual fee in full upon joining the practice.

Dr. Rozin will provide only emergency care for 30 days after your termination from the program. After this time Dr. Rozin will no longer be responsible for any aspect of your medical care and you should establish with and see your new physician for all medical issues. You and/or your insurance company as the case may be, will be responsible for any charges incurred for emergency care provided during this time.

I have read, understand and agree to the Payment Policies for ROZIN Internal Medicine.

______________________________ ______________________________

Signature Print Name

Date__________________________

Patient Personal Health Questionnaire
ROZIN Internal Medicine
Spencer I. Rozin, MD FACP

Name: ______________________ Sex: M / F Age: ________ Birthplace: ______________

Martial Status S / M / D / W Referred By: ______________________________

Employed By: ______________________ Highest Level of Education: HS College Post Grad

Why are you here today (Please list area of major concern if any):

____

____

____

Personal Medical History (MARK ALL THAT APPLY)

○ Heart Disease/Heart Attack
○ High Blood Pressure
○ Diabetes
○ High Cholesterol/Triglycerides
○ Stroke
○ Cancer
○ Thyroid Disease
○ Heart Murmur
○ Mitral Valve Prolapse
○ Heart Failure
○ Atrial Fibrillation
○ Irregular Heart Beat
○ Osteoporosis
○ Arthritis
○ Migraines/Headaches
○ Colon Polyps
○ Other: ______________________
○ Depression/Anxiety
○ Kidney Problems/Stones
○ Liver Problems
○ Lung Disease/Asthma
○ Stomach Ulcers
○ Irritable Bowel Syndrome
○ Diverticulosis
○ Sleep Apnea
○ Anemia/B12 Deficiency
○ Blood Clots
○ Gout
○ Fibromyalgia
○ Glaucoma
○ Meningitis
○ Sexually Transmitted Disease
○ Neurological Problems
○ Other: ______________________

Surgery (Check all that apply and year of surgery)

○ Tonsillectomy ______
○ Appendectomy ______
○ Gallbladder ______
○ Hernia ______
○ Hemorrhoids ______
○ Vasectomy ______
○ Cataracts ______
○ Tubal Ligation ______
○ C-Section #______
○ D & C #______
○ Sinus Surgery ______
○ Plastic Surgery ______
○ Thyroid ______
○ LASIK ______

Name: ______________________

Date: ______/______/______

Surgery (continued)

○ Breast Biopsy Left Right

○ Knee Surgery Left Right

○ Hip Surgery Left Right

○ Back Surgery #______ Level

○ Cancer Surgery __________________

○ Hysterectomy ___Abdominal ___Vaginal
Reason______________________________

○ Ovaries ___Present ___Removed

○ Ear Tubes/Surgery

○ Other ____________________________________

Childhood Illnesses

○ Mumps

○ Measles

○ Chicken Pox

○ Rheumatic Fever

○ Scarlet Fever

○ Other ___________________

Vaccines & Year Received

○ Tetanus ______

○ Influenza ______

○ Pneumonia ______

○ Hepatitis A ______

○ Hepatitis B ______

○ Shingles ______

○ Other ___________________

Smoking History

○ Never

○ Quit Year ______

○ Years Smoked ______

○ Want to Quit

○ Cigarettes
Amount per day_____ wk_____
Years _____

○ Cigar _____/day _____wk

○ Pipe _____/day _____wk

Alcohol History

○ Never

○ Quit Year ______

○ Want to Quit

○ Amount

Beer _____/day _____/wk _____/mo
Wine _____/day _____/wk _____/mo
Liquor _____/day _____/wk _____/mo

Family History

☐ Adopted or Unknown

Mother Age _____ Deceased (cause) _____________________
Medical Problems:

Father Age _____ Deceased (cause) _____________________
Medical Problems:

Brothers/Sisters

First Name			Medical Problems
________________	M / F	Deceased	________________________________
________________	M / F	Deceased	________________________________
________________	M / F	Deceased	________________________________
________________	M / F	Deceased	________________________________

Children

________________	M / F	Deceased	________________________________
________________	M / F	Deceased	________________________________
________________	M / F	Deceased	________________________________
________________	M / F	Deceased	________________________________

Other relatives not already listed (if known). Please list relationship

○ Heart Disease/Heart Attack ________	○ Depression/Anxiety ________
○ Heart Failure ________	○ Kidney Problems/Stones ________
○ High Blood Pressure ________	○ Liver Problems ________
○ Diabetes ________	○ Lung Disease/Asthma ________
○ High Cholesterol/Triglycerides ________	○ Blood Clots ________
○ Stroke ________	○ Neurological/Tremors ________
○ Thyroid Problems ________	○ Alzheimer's ________
○ Osteoporosis ________	○ Accidental/Suicide ________
○ Migraines/Headaches ________	○ Lupus or similar ________
○ Colon Polyps/Cancer ________	○ Cancer and Type ________________________
○ Other: ________________________	○ Other: ________________________

Exercise

Type

Frequency

Any Problems

Seat belt use

☐ Always ☐ over 75% ☐ 50-75% ☐ less than 50%

Health Screening

Mammogram	Year______	Results
PAP Smear	Year______	Results
Bone Density	Year______	Results
Prostate Exam	Year______	Results
Colonscopy/Sigmoidoscopy	Year______	Results
Cardiac Stress Test		
Treadmill	Year______	Results
Nuclear/Chemical	Year______	Results
Eye Exam	Year______	Results
Chest Xray	Year______	Results
TB Skin Test	Year______	Results
Other (CT's/Aorta Ultrasound)	Year ______	Results

Name: ________________________

Date: ______/______/______

Medications (Prescriptions/Vitamins/Supplements)

Medications		
Name	Dose	Frequency

Allergies	
Name	Reactions

Review of Symptoms (Please check if you have or have had ongoing problems with the following.)

General

○ Fatigue

○ Sleep Problems

○ Night Sweats

○ Weight Gain/Loss Amount_______ Over what period of time______

○ Fevers

○ Appetite Changes

○ Excessive Thirst

Skin

○ New or changing moles/lesions

○ Recurrent Rash

○ Rosacea

Neck

○ Pain

○ Swelling

Eyes

○ Double Vision

○ Blurry Vision

○ Changing Vision

○ Pain

○ Dry/Gritty Eyes

○ Other ___________________________

Ears/Nose/Throat/Sinus

○ Ringing in Ears

○ Decreased Hearing

○ Ear Pain

○ Recurrent Cold Sores/Mouth Ulcers

○ Persistent Hoarseness

○ Recurrent Sinus Infections

○ Sinus Draingage

Lungs/Breathing

○ Recurrent Cough

○ Sputum Production

○ Shortness of Breath

- ○ At Rest
- ○ With Exertion
- ○ Wakes me at night

○ Wheezing

○ Stop Breathing During Sleep

○ Snoring

○ Coughing up Blood

Heart

○ Chest Pain/Pressure/Fullness

○ Chest Tightness/Squeezing/Heaviness

○ Palpatations

○ Skipped Beats/Fluttering

○ Pass Out Spells

○ Leg Swelling

○ Leg/Buttock Pain or Cramps with Exertion

○ Must Sleep Propped Up

Stomach/Bowels

○ Difficulty with/Painful Swallowing
○ Heart Burn
○ Acid Reflux
○ Indigestion
○ Recurrent Nausea/Vomiting
○ Abdominal Pain
○ Bloating/Gassy
○ Constipation
  ○ BM Frequency ______
○ Diarrhea
  ○ BM Frequency ______
○ Change in Bowel Frequency
○ Change in Bowel Character
  ○ Size
  ○ Shape
  ○ Consistency
○ Blood In/On Stool
○ Blood on Toilet Tissue
○ Hepatitis/Jaundice
○ Pancreatitis
○ Lactose Intolerance
○ Food Intolerance(s)

Urinary

○ Pain/Burning with Urination
○ Loss of Urine with Coughing, Sneezing Laughing, Straining
○ Loss of Urine if can't get to the Bathroom Quickly
○ Blood in Urine

Women

○ Breast Pain/Nipple Discharge
○ Abnormal Menstrual Cycles
○ Vaginal Discharge
○ Painful Intercourse
○ Miscarriage #______
○ Abortions #______
○ Last Menstrual Cycle Date______

Men

○ Difficulty Getting Erections
○ Difficulty Maintaining Erections
○ Nighttime Urination #_____
○ Loss of Libido
○ Prostate Infections

Hematology

○ Easy Bruising/Bleeding
○ Transfusions

Neurological

○ Numbness/Tingling
○ Dizziness
○ Tremor
○ Seizures
○ Memory Problems
○ Muscle Weakness

Psychiatric

○ Depressed/Sad/Blue
○ Anxious/Nervous
○ Crying Spells
○ Poor Concentration
○ Decreased Motivation
○ Decreased Enjoyment of Activities
○ Suicidal Thoughts/Acts

Muscular

○ Muscle Pain
○ Joint Pain
○ Joint Swelling
○ Limitation of Joint Motion

Name: ___________________________

Date: ______/______/______

For Physician Use