ADDITIONAL PATIENT INFORMATION

Name		DOB	

ETHNICITY AND RACE IDENTIFICATION

RACE	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ I do not wish to share / respond	ETHNICITY	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I do not wish to share / respond
		PREFERRED LANGUAGE	

PROVIDERS WHO CARE FOR YOU (PRIMARY CARE MD / NURSE PRACTITIONER / SPECIALISTS)

	NAME OF SPECIALIST		**NAME OF SPECIALIST**
PRIMARY CARE MD	*Andrew M Romanowsky, MD*	**PHYSICIAN ASST**	*Eikatarine T Berube, PA-C* *Danielle J McGinty, PA-C* *Heather L Thyne, PA-C*
ALLERGY		OPHTHALMOLOGY	
CARDIOLOGY		ORTHOPEDICS	
DERMATOLOGY		PAIN MEDICINE	
ENDOCRNOLOGY		PODIATRY	
EAR, NOSE & THROAT		PSYCHIATRY	
GASTROENTEROLOGY		PULMONARY / SLEEP MEDICINE	
NEPHROLOGY / KIDNEY		RHEUMATOLOGY	
NEUROLOGY		UROLOGY	
OB/GYN		VASCULAR	
ONCOLOGY		OTHER	

CHIROPRACTORS, ACUPUNCTURISTS, HERBALISTS AND THERAPISTS

CHIROPRACTOR	
ACUPUNCTURIST	
HERBALISTS	
THERAPIST	
SOCIAL WORKER	

OTHER SUPPLIERS / DME SUPPLIERS FOR OXYGEN, C-PAP, DIABETIC SUPPLIES, ETC.

C-PAP	
DIABETIC SUPPLIES	
OXYGEN	

Today's Date: _____ Patient's Initials: _____

Patient's Name: _____ **DOB: _____**

CONSENT TO TREATMENT

I am presenting myself for examination and treatment at **Andrew M Romanowsky, MD LLC** and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the practice, and by its medical staff, or their designees, as in their professional judgment be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the practice.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

Date **Signature of Patient or Responsible Person**** **Relationship**

** By signing above, I acknowledge that **Andrew M Romanowsky, MD LLC** has informed me of their **Notice of Privacy Practices** for the protection and security of my healthcare information. I also acknowledge that upon request, **Andrew M Romanowsky, MD LLC** will provide me with a copy of their **Notice of Privacy Practices**.

FINANCIAL CONSENTS

Release of Information: Assignment of Benefits, Payment Guarantee

AUTHORIZATON TO RELEASE INFORMATION: **Andrew M Romanowsky, MD LLC** is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any information pertaining to the diagnosis and/or procedures relative to this practice visit(s). A photocopy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY: In consideration of services rendered, I hereby forever assign and give to **Andrew M Romanowsky, MD LLC** all rights, title and interest in the benefits payable for services rendered by said practice, provided by my policy (ies) of insurance. This transaction shall be for the recovery on said policy (ies) but shall not be construed to be an obligation of **Andrew M Romanowsky, MD LLC** to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company (ies) to pay directly to **Andrew M Romanowsky, MD LLC** all benefits due under said policy (ies) by reason of services rendered therein. I shall pay **Andrew M Romanowsky, MD LLC** for all charges in excess of the sums actually paid pursuant to said policy (ies). A photocopy of this authorization shall be considered as effective and valid as the original.

Date **Signature of Patient or Parent if Minor**

MEDICARE CERTIFICATION
(Medicare Patients Only)

Patient's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize **Andrew M Romanowsky, MD LLC** to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Andrew M Romanowsky, MD LLC** or one of its affiliates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I assign payment for the unpaid charges for certain physician's services. I understand that I am responsible for any health insurance deductibles and coinsurance.

Date **Signature of Patient**

AUTHORIZATION TO RELEASE INFORMATION

I allow **Andrew M Romanowsky, MD LLC** to speak to _____ // _____ regarding my care.
Name Relationship

I allow **Andrew M Romanowsky, MD LLC** to leave a message at my home or cell regarding any appointments and/or normal test results.

Date **Signature of Patient or Parent if Minor**

CONSENT TO HEALTH INFORMATION EXCHANGE

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

Date **Signature of Patient or Parent if Minor**

ANDREW M ROMANOWSKY, MD LLC
Financial Office Policy

FINANCIAL

Our office will make every attempt to bill your health insurance carrier for medical services rendered to you. It is your responsibility to provide us with timely and accurate information regarding your insurance policy. Please keep us updated as changes occur. **Andrew M Romanowsky, MD must be listed as your Primary Care Physician.**

Your insurance policy is a contract between you and your insurance company. Our relationship is with you, the patient. You are responsible for knowing your coverage. Our providers make every attempt to recommend medical care that is essential to your health. Please know your policy's limits and contact your insurer to verify coverage if you are not sure.

_____
Initials

CO-PAYS / DEDUCTIBLES

All primary care co-pays are due at the time of service. Patients with co-insurances and self-pay accounts are expected to make a payment at the time of service. Co-pays and deductibles apply to all visits in our practice, including non-provider clinical staff.

*** Please be advised you may not have a co-pay or deductible for preventative care. However, if both preventive and diagnostic care occur at the same visit, you may have a copay or deductible associated with the diagnostic service. Your provider will determine the proper coding after your visit, and we will bill you the co-pay and/or deductible per the payment explanation of benefits from your insurance carrier.*

_____
Initials

CANCELLATIONS / NO-SHOWS

To provide access for all practice patients, we ask that you provide at least a 24-hour notice if you need to cancel your appointment. This allows time for the staff to offer your appointment to another patient who is waiting to be seen. A missed appointment may be subject to a $50 fee for new patients, office procedures and physical appointments, and a $25 fee for follow-up and sick visit appointments.

_____
Initials

LATE APPOINTMENTS

If you arrive more than 15 minutes late for your appointment, you will be seen on a case-by-case basis, depending on the provider's schedule.

MASSACHUSETTS "PATIENT'S FIRST" ACT

- Please confirm with a member of our staff that we accept your insurance plan
- You may request a disclosure of the allowed amount and the amount of the service or procedure.
    - It may take up to two (2) days to obtain the allowed amount under our contracted fee schedule.
- You may obtain additional information in real time about applicable out-of-pocket costs from your insurance carrier's toll-free number or website. This information may be available on the back of your insurance card.
- If we are unable to provide a specific amount in advance due to an inability to predict the specific treatment or diagnosis code, we will provide the estimated maximum allowed amount.

  I waive the requirement for this notice for subsequent services or procedures that are part of a continued course of treatment.

_____
Initials

1. I have read and agree to the **Andrew M Romanowsky, MD LLC's** policy above.
2. This agreement remains in effect for all future services at **Andrew M Romanowsky, MD LLC**

Patient's Name: _____ Date of Birth: _____

Patient/Responsible Person's Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems? (*circle a number to indicate your answer.*)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

If you responded 'Not at all' to <u>both</u> questions 1 & 2, you do not need to complete the next section of form.

---

3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

TOTAL: _____

10. If you checked off any *problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult _____

Patient Name:_____ DOB: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Interpretation

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Andrew M Romanowsky, MD, LLC **Medical Health Questionnaire - ROS**

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Review of Systems: *Current Personal Medical Symptoms*

Constitutional symptoms			
	Recent weight loss	Yes	No
	Recent weight gain	Yes	No
	Fever	Yes	No
	Chills	Yes	No
	Trouble sleeping	Yes	No
Eyes	Redness or itching	Yes	No
	Visual blurring	Yes	No
	Eye disease or injury	Yes	No
Ear/Nose/Mouth/Throat			
	Hearing loss	Yes	No
	Ringing in ears	Yes	No
	Earaches, infections	Yes	No
	Ear drainage	Yes	No
	Nose bleeds	Yes	No
	Frequent nasal stuffiness	Yes	No
	Runny Nose	Yes	No
	Postnasal drip	Yes	No
	Frequent sinus infections	Yes	No
	Mouth sores	Yes	No
	Swollen glands in neck	Yes	No
	Hoarse voice or voice changes	Yes	No
Cardiovascular			
	Chest pain or discomfort	Yes	No
	Tightness	Yes	No
	Palpitations	Yes	No
	Short of breath when walking	Yes	No
	Short of breath when lying flat	Yes	No
	Swelling of feet, ankles or hands	Yes	No
	Swelling of legs	Yes	No
	Sudden awakening from sleep with shortness of breath	Yes	No
Respiratory			
	Chronic or frequent cough	Yes	No
	Coughing up mucous/phlegm	Yes	No
	Coughing up blood	Yes	No
	Shortness of breath	Yes	No
	Wheezing	Yes	No
	Painful Breathing	Yes	No
	Snoring	Yes	No
Gastrointestinal			
	Abdominal pain	Yes	No
	Nausea and/or vomiting	Yes	No
	Frequent heartburn	Yes	No
	Swallowing difficulties	Yes	No
	Diarrhea	Yes	No
	Constipation	Yes	No
Urinary			
	Burning or pain (dysuria)	Yes	No
	Blood in urine (hematuria)	Yes	No
Musculoskeletal			
	Joint pain	Yes	No
	Muscle pain	Yes	No
	Swelling of joints	Yes	No
	Leg pain/cramps	Yes	No
Integumentary (skin)			
	Rash, hives or itching	Yes	No
	Lumps	Yes	No
	Change in skin color	Yes	No
	Recurrent skin infections	Yes	No
Neurological			
	Frequent/recurring headaches	Yes	No
	Dizziness	Yes	No
	Weakness	Yes	No
	Numbness or tingling sensations	Yes	No
	Restless Legs	Yes	No
	Excessive Daytime Sleepiness	Yes	No
Psychiatric			
	Nervousness	Yes	No
	Stress	Yes	No
	Depression	Yes	No
	Memory Loss	Yes	No
Endocrine			
	Cold intolerance	Yes	No
	Heat intolerance	Yes	No
	Excessive thirst or urination	Yes	No
Hematologic/Lymphatic			
	Ease of bruising	Yes	No
	Ease of bleeding	Yes	No
	Swollen glands	Yes	No
	Fatigue	Yes	No
Allergic/Immunologic			
	Hay fever symptoms (itchy, runny nose/sneezing)	Yes	No
	Known food allergies	Yes	No
	Known environmental allergies	Yes	No
	Known drug/medication allergies	Yes	No

***Additional information not listed above**:

_____

_____

Patient's Initials: _____ Date Completed: _____ Rev 01/2022

Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____

Date of Birth: _____ Medical Record #: _____

Address: _____

_____

Telephone #: _____ Cell #: _____

☐ I hereby authorize _____
to disclose / release my Protected Health Information as requested on this authorization to:

Andrew M Romanowsky, MD LLC
33 Bartlett St Ste 206
Lowell, MA 01852-1317

Tel: 978-458-1293 / Fax: 978-458-6953

1. **Specific information to be disclosed / released:**

- ✓ Progress Notes / Office Visits: Last two (2) progress notes
- ✓ Diagnostic Imaging: All imaging reports on file
  - o Breast Cancer Screening: Mammography
- ✓ Labs: One (1) Year
  - o Cervical Cancer Screening
  - o Colon Cancer Screening - Cologuard, Fecal Globin by Immunochemistry (InSure®)
- ✓ Procedures: All procedures
  - o Colon Cancer Screening – Colonoscopy
- ✓ Specialists: Last progress note(s)
  - o Diabetic Eye Exam (if applicable)
- ✓ Vaccination Record

Purpose of Release: **New Primary Care Physician**

Example: New Primary Care Physician / New Cardiologist / Care Coordination with other Specialist / Personal Use

CONTINUE ON REVERSE SIDE / PAGE 2

Patient's Name: _____ DOB: _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, the authorized parties will release such information about me if it exists.

   Do **NOT** release the following information:

   - ☐ HIV/AIDS
   - ☐ Genetic Information
   - ☐ Mental Health
   - ☐ Sexually Transmitted Diseases
   - ☐ Treatment for alcohol and/or drug abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying the authorized parties. I understand that any previously disclosed information would not be subject to my revocation request.

5. 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 or my eligibility for benefits, unless otherwise described in the space provided here:

   _____

   _____

This form must be fully complete before signing.

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Print Patient's Name | Date of Birth

_____ _____

Print Name of Legal Representative (if applicable) | Relationship to Patient

☐ *Please accept my facsimile signature as an original*