

ADDITIONAL PATIENT INFORMATION

Name		DOB	
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ETHNICITY AND RACE IDENTIFICATION

RACE	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not wish to share / respond	ETHNICITY	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> 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	<i>Andrew M Romanowsky, MD</i>	PHYSICIAN ASST	<i>Eikatarine T Berube, PA-C Danielle J McGinty, PA-C Heather L Thyne, PA-C</i>
ALLERGY		OPHTHALMOLOGY	
CARDIOLOGY		ORTHOPEDECS	
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

AUTHORIZATION 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 preventative 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: _____

ANDREW M ROMANOWSKY, MD LLC

33 Bartlett Street, Suite 206, Lowell, MA 01852

Tel: 978-458-1293

Fax: 978-458-6953

Patient Name: _____

Date of Birth: _____

ANNUAL LIFESTYLE QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems? *Check off the most appropriate answer.*

PHQ-9	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GAD-7	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Name: _____

Date of Birth: _____

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation.

1. Have you had a fall in the past year?
 Yes, with serious injury No
 Yes, with minor injury Declined to Answer
 Yes, with no injury
2. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
 Very Hard Not Very Hard
 Hard Not Hard at All
 Somewhat Hard Declined to Answer
3. Within the past 12 months, you worried that your food would run out before you got the money to buy more.
 Often True Never True
 Sometimes True Declined to Answer
4. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
 Yes Declined to Answer
 No
5. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
 Yes Declined to Answer
 No
6. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?
 Yes Declined to Answer
 No
7. Did you have a drink containing alcohol in the past year?
 Yes Declined to Answer
 No

If Yes:

How often did you have six or more drinks on one occasion in the past year?

- | | |
|--|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> 2-3 times per week |
| <input type="checkbox"/> Less than monthly | <input type="checkbox"/> 4 or more times a week |
| <input type="checkbox"/> 2-4 times a month | <input type="checkbox"/> Declined to Answer |

How many drinks did you have on a typical day when you were drinking in the past year?

- | | |
|--|---|
| <input type="checkbox"/> 1 or 2 drinks | <input type="checkbox"/> 7 to 9 drinks |
| <input type="checkbox"/> 3 or 4 drinks | <input type="checkbox"/> 10 or more drinks |
| <input type="checkbox"/> 5 or 6 drinks | <input type="checkbox"/> Declined to Answer |

How often did you have a drink containing alcohol in the past year?

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 2 to 3 times a week |
| <input type="checkbox"/> Monthly or less | <input type="checkbox"/> Daily or almost daily |
| <input type="checkbox"/> 2 to 4 times a month | <input type="checkbox"/> Declined to Answer |

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 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
 - Breast Cancer Screening: Mammography
- ✓ Labs: One (1) Year
 - Cervical Cancer Screening
 - Colon Cancer Screening - Cologuard, Fecal Globin by Immunochemistry (InSure®)
- ✓ Procedures: All procedures
 - Colon Cancer Screening – Colonoscopy
- ✓ Specialists: Last progress note(s)
 - 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

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