WELCOME TO THE PRACTICE OF UNIVERSITY INTERNAL MEDICINE, INC.

407 East Ave, Suite 120
Pawtucket, RI 02860
(401)725-4700

As a new patient to the practice, we request that you **arrive 30 minutes prior to your scheduled appointment time.**

1) We would appreciate any medical records from your previous doctor as well as Immunization Records, if available, be sent to us prior to your scheduled initial appointment. You may also hand carry the records to your initial appointment. **Enclosed is a medical release form, please forward the completed form to your previous physician.**

2) Please bring all paper work **completed** and signed that has been sent to you from this office.

3) Be sure to have your most recent insurance card and a photo ID. We will ask to see these at each subsequent appointment. **If your insurance requires a PCP, please contact your insurance company and change your PCP to the physician you will be seeing in our office. If this is not done prior to your visit, your appointment will be rescheduled**

4) Co-payments will be collected at check-in, for your convenience we accept cash, checks, and all major credit cards. There will be $10.00 service charge for co-payments not paid at the time of service. There is a $30.00 fee for any returned checks

5) Bring all medications including any over-the-counter medications that you are taking. Bring the actual bottles if you like, this will make it much easier for the doctor to be sure of dosages.

6) Family medical history is very important, please check with family members regarding any health issues that they may have and write them down for the doctor.

7) If there may be a language barrier, please bring an interpreter with you to each appointment

8) If you must cancel your appointment, we request **24-hour notice** so that we may accommodate other patients; otherwise, there will be a $75.00 fee. **If you fail to keep your new patient appointment no future appointments will be made.**

9) **There is a provider on call after hours for emergencies only. No medications will be refilled after hours or on weekends. If you will be needing any medication refills, please contact the office during normal business hours, 8:30AM – 4:30PM Monday – Friday, excluding holidays.**

University Internal Medicine, Inc.
Patient Registration Form

Last 4 digits of Patient's Social Security Number ______________________________

Patient's Name ____
(First) (Middle Initial) (Last)

☐ Male ☐ Female Date of Birth ___/ ___/ ___ Marital Status ____________________

Address ____
(Street) (City, State, Zip Code)

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Preferred Phone (circle one) Home/Cell/Work

Email Address ____

Emergency Contact Person ______________________ **Phone #** ________________

Employed ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐

Employment Information

Patient's Employer ____

Employer's Address ____________________________ Phone # ________________

Medical Insurance Coverage, Please Provide Copy of Insurance Card:

Primary Insurance Carrier ____

Policy # ______________________ Group # ______________________

Subscriber's Name ____________________________ Date of Birth _____/ _____/ _____

Subscriber's Employer ____

Relationship to Patient ______________

Secondary Insurance Carrier ____

Policy # ______________________ Group # ______________________

Subscriber's Name ____________________________ Date of Birth _____/ _____/ _____

Subscriber's Employer ____

Relationship to Patient ______________

We want to make sure that we identify and address each patient's needs and ensure that all patients get the best care possible.

<table>
<tr>
<td>
<u>Race:</u>
Which of the following best describes your race? (Select all that apply)
_______ American Indian or Alaska Native
_______ Asian
_______ Black or African American
_______ Native Hawaiian or Other Pacific Islander
_______ White
_______ Refused
_______ Unknown
</td>
<td>
<u>Ethnicity:</u>
Which of the following best describes your ethnicity?
_______ Latino/Hispanic
_______ Not Hispanic or Latino
_______ Other
_______ Refused
</td>
</tr>
<tr>
<td>
<u>Language:</u>
Which language do you prefer to use to talk with your Health Care team?
____
</td>
<td>
<u>Sex Assigned at Birth:</u>
_______ Female
_______ Male
_______ Unknown
</td>
</tr>
<tr>
<td>
<u>Gender Identity:</u>
_______ Male
_______ Female
_______ Transgender Male/Female-to-Male
_______ Transgender Female/Male-to-Female
_______ Genderqueer; Neither Exclusively Male nor Female
_______ Declined
_______ Other
</td>
<td>
<u>Sexual Orientation:</u>
_______ Straight
_______ Gay
_______ Lesbian
_______ Bisexual
_______ Other
_______ Unknown
_______ Declined
</td>
</tr>
</table>

I authorize all Health Care Providers including insurance companies, HMO's, hospital and medical service corporations to pay directly to University Internal Medicine, Inc. all benefits due under said policy by reason of services rendered. I also authorize the release of any medical information necessary to process claims for the professional services rendered to me. I understand that I am ***financially responsible to University Internal Medicine, Inc. for charges not covered*** by this authorization and do hereby agree upon receipt of bill to pay directly in full.

Print Name: ____

Signature: ______________________________________ Date: _____/_____/_____

Relationship (if signed by family member) ______________________________

Date:
Signature:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:						**DOB:**
Marital status: ☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	
Previous or referring doctor:				**Date of last physical exam:**		

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles	☐ Mumps	☐ Rubella	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Question		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

University Internal Medicine, Inc.

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Fax: (401) 725-4740

Release of Personal Medical Information Consent Form

I ____

(Print Patient's Name) (Date of Birth)

authorize any University Internal Medicine Physician (Dr. Christine Herbert, Dr. David Marcoux, Dr. Felicia Meila, Jordan Jutras, PA-C, Katherine Maiorisi, PA-C, Anthony Ramicone, PA-C, Derrick Robinson, PA-C) to release any medical information pertinent to my care to (please, print legibly):

Name: ______________________ Relationship: ___________ Phone Number: _______________

Name: ______________________ Relationship: ___________ Phone Number: _______________

Name: ______________________ Relationship: ___________ Phone Number: _______________

Name: ______________________ Relationship: ___________ Phone Number: _______________

____ _________________________

Patient Signature (Guardian if minor) Date

____ _________________________

Witness Signature Date

Note: If patient is a minor, the parent or guardian must sign. If the patient is an adult and does not sign this consent form, the party signing must provide legal documentation providing their authority to do so.

This authorization will remain in effect indefinitely unless written documentation is received by this office terminating authorization, signed and dated by the patient.

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Authorization for Release of Medical Information

Patient Name: ______________________________ **Date of Birth:** ______________

Address: ____

City, State Zip: ____

Patient's Primary Care Physician: ____________________________________

Records request to be □ **received from** □ **sent to** □ **verbal** (please check one)

Physician/Facility Name: ____

Address: ____

City, State Zip: ____

Physician's Phone: ______________________ **Physician's Fax:** ______________

Medical Information (Excluding Sensitive Information)

□ Information and records or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease.

□ Only those specific records as described below:

____

Sensitive Information

□ In addition, I hereby specifically consent to the disclosure and release of "sensitive medical information" concerning my treatment of (Check all that apply):

□ Mental illness □ HIV testing □ Services paid in full by me □ Drug abuse/dependency
□ Psychiatric notes □ Alcoholism □ Sexually transmitted diseases □ Genetic information
□ Other: ____

Information Format

□ Paper copies □ Electronic records on a CD

I may withdraw this authorization at any time provided that I do so in writing. **University Internal Medicine, Inc.** is released from any responsibility or liability for any records that may have already been disclosed prior to the written notification or cancellation of this authorization.

By signing this release, I acknowledge that my records ***are not encrypted***. Once the records have left the **University Internal Medicine, Inc.** facility, whether picked up by me or sent in any fashion per my request, the protection of these records is no longer the responsibility of **University Internal Medicine, Inc.**

This Authorization expires on ___/___/_____. If no expiration date is given, then this authorization shall remain in effect for one year.

____ ________________________

Patient Signature (Guardian if minor) or Legal Representative Date

Note: If patient is a minor, the parent or guardian must sign. If the patient is an adult and does not sign this consent form, the party signing must provide legal documentation providing their authority to do so.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please, review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by University Internal Medicine, Inc., in any form, whether electronically, on paper, or orally, be kept confidential. This Act give you, the patient, significant rights to understand and control how your health information is used. "HIPAA" provides penalties for individuals or companies that misuse personal health information.

As required by "HIPAA", University Internal Medicine, Inc. has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may disclose Protected Health Information (PHI) to doctors, nurses, technicians, or other personnel outside of this office who are involved in your medical care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may share PHI with your health insurance to receive payment for health care service we provide to you. We may also share PHI with billing companies and companies that process our health care claims.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and patient quality of care.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment or other health related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your PHI, which you may exercise by resenting a written request to the Office Manager:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI information from us by alternative means or alternative locations.

- The right to inspect and copy your PHI. This must be requested in writing and we will respond to this request within 30 days. If you request a copy of your PHI, a fee will be charged for which you will be notified in advance.
- The right to amend you PHI. If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include a reason for the request. We will respond within 60 days of your request. We may deny your request if the PHI is 1) correct and complete, 2) not created by this office, 3) not allowed to be share with you, or 4) not in our record. If we deny your request, we will inform you of a reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.
- The right to a paper copy of this notice from University Internal Medicine, Inc.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

This notice is effective, April 14, 2003, and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisioned effective for all PHI that we maintain. We will post, and you may request, a copy of a revised Notice of Privacy Practices from this office.

Modification – Effective September 23, 2013

To comply with "HIPAA" Mega-Rule (Federal Registry, Department of Health and Human Services, 45 CFR Parts 160 and 164) from January 25, 2013, we are adding the following criteria to our Notice of Privacy Practice:

- Release authorizations. Certain disclosures and uses of protected information require the patient's authorization as listed on our Authorization for Release of Medical Records" form.
  - University Internal Medicine, Inc. does not use PHI for any marketing purposes.
  - University Internal Medicine, Inc. does not sell any PHI
- Fundraising. University Internal Medicine, Inc. does not do any type of fundraising that would use PHI
- Restricting information release. A patient who pays for a service in full and out of pocket can request that the office not disclose any information about that service to an insurance company. The patient has to put the request in writing, and the request has to spell out what information the patent wants to restrict and what insurance company is not to receive it.
- Breach notification. The office will notify patients in writing if a breach in their protected information were to occur.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the U.S. Department of Health & Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, DC 20201, about violations of the provisions for this notice or the policies and procedures of our office. Your complaint will not alter or affect the quality of care that we provide to you

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NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have received a copy of University Internal Medicine, Inc.'s Notice of Privacy Practices.

____ ________________________

Signature Date

____

Signature of Legal Guardian

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

____

Date Staff Initials Reason