ALEXES HAZEN MD

917·301·6563

www.alexeshazenmd.com

535 5th Avenue 29th Floor

New York, NY 10017

NEW PATIENT INTAKE FORM

PLEASE COMPLETE FORM WITH LEGAL NAME/INFORMATION

ALL INFORMATION IS CONFIDENTIAL

PLEASE PRINT

TODAY'S DATE: _____

PATIENT DEMOGRAPHICS

FIRST NAME:_____ LAST NAME: _____

PREFERRED NAME:_____ PRONOUN:_____ GENDER:_____

DATE OF BIRTH:_____ SS#: _____

HOME ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE: _____

EMAIL:_____ PREFERRED METHOD OF CONTACT: _____

WOULD YOU LIKE TO RECEIVE PROMOTIONAL INFORMATION? ☐YES ☐NO

RACE:_____ ETHNICITY:_____ PREFERRED LANGUAGE:_____ INTERPRETER: ☐YES ☐NO

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐OTHER: _____

EMERGENCY CONTACT:_____ RELATIONSHIP TO PATIENT: _____

PHONE:_____ EMAIL: _____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

MENTAL HEALTH CARE PROVIDER:_____ PHONE:_____

THERAPIST:_____ PHONE:_____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

WHO MAY WE THANK FOR THE REFERRAL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ MEMBER ID: _____

GROUP NAME:_____ GROUP NUMBER: _____

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT: _____

INSURED DATE OF BIRTH:_____ SS #:_____ PHONE #: _____

SECONDARY INSURANCE:_____ MEMBER ID: _____

GROUP NAME:_____ GROUP NUMBER: _____

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT: _____

INSURED DATE OF BIRTH:_____ SS #:_____ PHONE #: _____

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INFORMATION ABOUT YOUR VISIT

REASON FOR CONSULTATION:

_____

_____

_____

HISTORY AND PHYSICAL:

HEIGHT:_____WEIGHT:_____

ALLERGIES TO MEDICATION: ☐YES ☐NO

MEDICATION: REACTION:

_____ _____

_____ _____

_____ _____

PLEASE LIST ALL MEDICATIONS AND HERBAL SUPPLEMENTS YOU ARE TAKING (INCLUDING VITAMINS & HERBS, SLEEP AIDS, ETC.):

_____

_____

_____

DO YOU SMOKE OR USE TOBACCO PRODUCTS: ☐YES ☐NO _____

HOW MANY PER DAY:_____HOW MANY YEARS: _____

DO YOU CONSUME ALCOHOL: ☐YES ☐NO _____

HOW MANY DRINKS CONTAINING ALCOHOL PERWEEK: _____

RECREATIONAL DRUGS: ☐YES ☐NO _____

FREQUENCY OF USE: _____

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MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER BEEN TREATED FOR (CHECK ALL THAT APPLY):

☐ MALIGNANT HYPERTHERMIA	☐ THYROID PROBLEM	☐ MENTAL ILLNESS
☐ AUTOIMMUNE DISORDER	☐ BULIMIA OR ANOREXIA	☐ DRUG DEPENDENCY
☐ CHRONIC ILLNESS	☐ HEPATITIS/JAUNDICE	☐ DEPRESSION
☐ HEART DISEASE	☐ ULCERS	☐ LUNG DISEASE
☐ HEART ATTACK	☐ EPILEPSY/SEIZURES	☐ CANCER
☐ STROKE	☐ COLD SORES	☐ SERIOUS ACCIDENT
☐ HIGH BLOOD PRESSURE	☐ MITRAL VALVE PROLAPSE	☐ SLEEP APNEA
☐ BLOOD DISORDER	☐ KIDNEY PROBLEMS	☐ CPAP MACHINE
☐ BLOOD CLOTTING DISORDER	☐ SHORTNESS OF BREATH	☐ LATEX ALLERGY
☐ ANEMIA	☐ ASTHMA	☐ ENVIROMENTAL ALLERGY
☐ DIABETES	☐ EMPHYSEMA	☐ OTHER:_____

IF YOU HAVE ANY OF THE ABOVE, PLEASE EXPLAIN:

_____

_____

_____

PREVIOUS SURGERIES (TYPE/DATE):

_____

_____

_____

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PHARMACY INFORMATION

AS A BENEFIT TO OUR PATIENTS, WE'VE PARTNERED WITH CAPSULE TO OFFER FREE SAME-DAY PRESCRIPTION DELIVERY TO OUR PATIENTS IN NYC, WESTCHESTER, HOBOKEN, AND JERSEY CITY, SO THEY CAN SAFELY OBTAIN THEIR MEDICATIONS. YOUR HEALTH AND SAFETY ARE OUR TOP PRIORITY. WE WILL BE SENDING PRESCRIPTIONS TO CAPSULE.

HOW IT WORKS:

1. WE SEND YOUR PRESCRIPTION TO CAPSULE
2. CAPSULE TEXTS YOU WITHIN AN HOUR TO SCHEDULE YOUR FREE SAME-DAY DELIVERY
3. CAPSULE WILL SAFELY DELIVER YOUR MEDICATION ANYWHERE IN THE FIVE BOROUGHS OF NYC, WESTCHESTER, HOBOKEN, OR JERSEY CITY
4. IF YOU HAVE ANY QUESTIONS, YOU MAY TEXT OR CALL CAPSULE AT (212) 675-3900

PLEASE INDICATE IF YOU WOULD PREFER TO HAVE YOUR MEDICATIONS SENT TO AN ALTERNATE PHARMACY.

❑ I WOULD PREFER TO HAVE MY MEDICATION SENT TO AN ALTERNATE PHARMACY (COMPLETE BELOW)

PHARMACY NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

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PATIENT CONSENT FORM

PLEASE INITIAL THE FOLLOWING:

- THE ABOVE INFORMATION IS CURRENT AND CORRECT TO THE BEST OF MY KNOWLEDGE._____ Initial Here
- I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO INSURANCE COMPANIES AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. _____ Initial Here
- I GIVE MY PERMISSION TO BE TREATED BY DR. ALEXES HAZEN AND STAFF NOW AND IN THE FUTURE AND ASSIGN ALL BENEFITS DIRECTLY TO DR. ALEXES HAZEN. I ASSUME FULL RESPONSIBILITY FOR MY BALANCE REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM. IN THE EVENT THAT MY INSURANCE COMPANY IS BILLED, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN(S) OR SUPPLIER OF RENDERED SERVICES. IF MY INSURANCE COMPANY FAILS TO PAY FOR SERVICES OR DOES NOT PAY A CLAIM IN FULL, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF CHARGES FOR SERVICES RENDERED._____ Initial Here

_____ _____ _____

Signature *Printed Name* *Date*

AUTHORIZATION AND CONSENT TO PHOTOGRAPH ANDPUBLICATION

THE UNDERSIGNED HEREBY AUTHORIZES DR. ALEXES HAZEN AND THE ATTENDING PRACTITIONER TO PHOTOGRAPH OR PERMIT OTHER DR. ALEXES HAZEN STAFF TO PHOTOGRAPH ME, THE PATIENT, WHILE UNDER THE CARE OF DR. ALEXES HAZEN.

THE UNDERSIGNED AGREES THAT DR. ALEXES HAZEN AND THE ATTENDING PRACTITIONERS MAY USE AND PERMIT OTHER PERSONS TO USE THE NEGATIVES OR PRINTS PREPARED FROM SUCH PHOTOGRAPHS FOR SUCH PURPOSES AN IN SUCH MANNER AS EITHER MAY DEEM APPROPRIATE. THE UNDERSIGNED AGREES THE PHOTOGRAPHS MAY BE USED FOR PURPOSES INCLUDING, BUT NOT LIMITED TO, AND DISSEMINATION TO PRACTITIONERS, HEALTH PROFESSIONALS, AND MEMBERS OF THE PUBLIC FOR EDUCATIONAL TREATMENT, RESEARCH, SCIENTIFIC, PUBLIC RELATIOINS, AND CHARITABLE PURPOSES AND THAT SUCH DISSEMINATION MAY BE ACCOMPLISHED IN ANY MANNER AND THAT SUCH USE IS SUBJECT ONLY TO THE FOLLOWING LIMITATIONS:

THE UNDERSIGNED HAS ENTERED INTO THIS AGREEMENT IN ORDER TO ASSIST THE SCIENTIFIC TREATMENT, EDUCATIONAL, PUBLIC RELATIONS, AND CHARITABLE GOALS HEREBY WAIVES ANY RIGHT TO COMPENSATION FOR SUCH USES BY REASON OF THE FOREGOING AUTHORIZATIONS, AND THE UNDERSIGNED AND HIS SUCCESSORS AND ASSIGNS HEREBY HOLD DR. ALEXEZ HAZEN AND THE ATTENDING PRACTITIONER AND THEIR SUCCESSORS AND ASSIGNS HARMLESS FROM AND AGAINST ANY CLAIM FOR INJURY OR COMPENSATION RESULTING FROM THE ACTIVITIES AUTHORIZED BY THIS AGREEMENT.

THE TERM “PHOTOGRAPH”, AS USED IN THE FOREGOING AGREEMENT SHALL MEAN MOTION PICTURE OR STILL PHOTOGRAPHY OR DIGITAL PHOTOGRAPHY IN ANY FORMAT, AS WELL AS VIDEO-TAPE, VIDEODISC AND ANY OTHER MECHANICAL MEANS OF RECORDING AND REPRODUCING IMAGES.

_____ _____ _____

Signature *Printed Name* *Date*

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HIPAA PRIVACY POLICY

It is the policy of the practice of Alexes Hazen, M.D.. that the physician and staff preserve the integrity and confidentiality of protected health information pertaining to our patients. The purpose of this policy is to ensure that our practice has the necessary information to provide the highest quality of medical and surgical care possible while protecting the confidentiality of our patients. To that end this practice will:

1) adhere to the standards set forth in this Privacy Policy;

2) collect, use, and disclose protected health information in conformance with state and federal laws, and with current patient agreements and authorization, as appropriate. This practice will not use or disclose protected health information for use outside the office, such as marketing, employment, insurance applications, etc. without a written authorization from the patient;

3) use and disclose protected health information to remind patients of their appointments only with their consent;

4) recognize that protected health information collected from patients must be accurate, complete, and available when needed. This practice will implement reasonable measures to protect the integrity of all patient information;

5) recognize that patients have a right to privacy. This practice will respect the patient's privacy to the extent that the highest possible medical care is delivered with efficient administration of the facility;

6) act as responsible stewards and treat all protected health information as sensitive and confidential. Consequently, this practice will treat all protected health information as confidential in accordance with professional ethics, accreditation standards, and legal requirements, and will not disclose protected health data unless the patient has properly consented to release;

7) recognize that, although the practice owns the medical record, the patient has a right to inspect and obtain a copy of his/her protected health information. In addition, patients have a right to request an amendment to their medical record if they believe the information is inaccurate or incomplete. This practice will permit patients to access their medical records, and will provide patients an opportunity to request the correction of inaccurate or incomplete protected health information in their medical records in accordance with the law and professional standards;

8) maintain a list of all disclosures of protected health information for purposes other than for treatment and payment procedures for each patient. A list will be provided to patients upon their written request;

9) adhere to any restrictions concerning the use or disclosure of protected health information that patients have requested, and that have been approved by this practice.

I have read and understand this document.

_____ _____ _____

Signature *Printed Name* *Date*

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FEE DISCLOSURE FOR OUT-OF-NETWORK PATIENTS

New York State "Surprise Law" April 1, 2015

IF DR. ALEXES HAZEN DOES NOT PARTICIPATE IN THE NETWORK OF YOUR HEALTHCARE PLAN THE AMOUNT BILLED TO YOU FOR THE **OFFICE VISIT** IS APPROXIMATELY: **$300 FOR CONSULTATIONS/$150 FOR FOLLOW UPS**

THIS AMOUNT DOES NOT INCLUDE THE AMOUNT FOR OTHER SERVICES THAT MAY BE PROVIDED DURING THE OFFICE VISIT. SUCH SERVICES MAY INCLUDE INJECTIONS, MINOR OFFICE PROCEDURES, ETC. **IF THESE SERVICES ARE PROVIDED, THE AMOUNT BILLED FOR THE SERVICES MAY BE HIGHER.** THE AMOUNT OF THESE SERVICES CAN BE PROVIDED TO YOU AT YOUR REQUEST.

IT IS IMPORTANT FOR YOU TO UNDERSTAND WHAT YOUR HEALTH CARE PLAN COVERS IF YOU OBTAIN SERVICES FROM AN OUT-OF- NETWORK PHYSICIAN.

- YOUR PLAN MAY NOT COVER OUT-OF-NETWORK SERVICES.
- IF YOUR PLAN COVERS OUT-OF-NETWORK SERVICES, YOUR PLAN MAY REQUIRE HIGHER COPAYS, DEDUCTIBLES, AND COINSURANCE FOR OUT-OF-NETWORK CARE.
- IN ADDITION, DR. ALEXES HAZEN MAY REFER YOU TO ANOTHER PHYSICIAN, PHYSICAL THERAPIST, OR OTHER HEALTH CARE PROVIDER OR FACILITY. THOSE REFERRALS MAY OR MAY NOT BE IN YOUR HEALTH NETWORK. PLEASE CALL TO FIND OUT IF THOSE INDIVIDUALS ARE A PART OF YOUR PLAN BEFORE YOU SCHEDULE AN APPOINTMENT.

I HAVE REVIEWED THE INFORMATION PROVIDED ABOVE AND UNDERSTAND THAT:

- I HAVE THE CHOICE OF USING EITHER A "HEALTH PLAN" PARTICIPATING OR NON-PARTICIPATING HEALTH CARE PROFESSIONAL OR FACILITY.
- I UNDERSTAND THAT IF I CHOOSE TO USE A NON-PARTICIPATING HEALTH CARE PROFESSIONAL OR FACILITY, SUCH SERVICES MAY NOT BE COVERED UNDER MY PLAN IF MY PLAN DOES NOT HAVE OUT-OF-NETWORK BENEFITS.
- IF MY PLAN HAS OUT-OF-NETWORK BENEFITS, I UNDERSTAND THAT BY USING MY OUT-OF-NETWORK BENEFITS I MAY INCUR GREATER COSTS FOR WHICH I WILL BE FINANCIALLY RESPONSIBLE THAN IF I HAD OBTAINED SERVICES FROM A "HEALTH PLAN" PARTICIPATING HEALTH CARE PROFESSIONAL OR FACILITY.

I HAVE MADE THE FOLLOWING DECISION:

☐ I WISH TO USE MY IN-NETWORK BENEFITS AND UTILIZE A "HEALTH PLAN" PARTICIPATING HEALTH CARE PROFESSIONAL OR FACILITY.

☐ I WISH TO OBTAIN SERVICESFROM Dr. Alexes Hazen. I UNDERSTAND SHE IS **NOT** A "HEALTH PLAN" PARTICIPATING HEALTH CARE PROFESSIONAL. I ALSO ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY WITH THIS FORM.

_____ _____ _____

Signature *Printed Name* *Date*

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INSURANCE CHECKS SENT TO THE PATIENT

I HAVE BEEN INFORMED BY DR. ALEXES HAZEN THAT THE CHECKS FROM MY INSURANCE COMPANY MAY BE SENT DIRECTLY TO ME.

THE EMPIRE PLAN (GOVERNMENT WORKERS) WILL SEND CHECKS TO THE PATIENT.

I AGREE TO MAIL THESE INSURANCE CHECKS TO:

DR. ALEXES HAZEN

535 5th Avenue 29FL New York, NY 10017

I AGREE AND ACKNOWLEDGE NOT TO CASH OR DEPOSIT THESECHECKS.

IN THE EVENT I FALSELY WITHOLD SUCH CHECKS I AGREE AND ACKNOWLEDGE THAT I AM ULTIMATLY RESPONSIBLE FOR THE AMOUNT OF THESE CHECKS DUE TO DR. ALEXES HAZEN.

Signature _____ *Printed Name* _____ *Date* _____