DOCS MEDICAL INC
DOCSMEDICALGROUP.COM

PATIENT INFORMATION

NAME: _____ DOB: _____ SOCIAL SECURITY#: _____

SEX AT BIRTH: _____ SEXUAL ORIENTATION: _____ GENDER IDENTITY: _____

ADDRESS: _____ APT#: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE (HOME): _____ (CELL): _____ E-MAIL: _____

EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC RACE: _____ LANGUAGE: _____

EMERGENCY CONTACT

NAME: _____ PHONE: _____ RELATIONSHIP: _____

GUARANTOR/PARENT INFORMATION

NAME: _____ DOB: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY HOLDER: _____ DOB: _____

SECONDARY INSURANCE: _____ POLICY HOLDER: _____ DOB: _____

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Have you had your annual physical in the past 12 months? ☐ YES ☐ NO

MEDICAL HISTORY OUTLINE: (PLEASE FILL AND COMPLETE, ALL INFORMATION IS REQUIRED**)**

REASON FOR VISIT: _____ **DATE:** _____

NAME: _____ **DOB**: _____

LAST PRIMARY CARE VISIT: ☐ LESS THAN 6 MONTHS ☐ MORE THAN 6 MONTHS ☐ MORE THAN 1 YEAR

WOULD YOU LIKE YOUR OFFICE VISIT NOTE FAXED? ☐ YES ☐ NO

PREFERRED PHARMACY: _____ LOCATION: _____

CURRENT MEDICATIONS: ☐ NONE

DRUG: _____ **DOSE**: _____ **FREQUENCY**: _____

DRUG: _____ **DOSE**: _____ **FREQUENCY**: _____

DRUG: _____ **DOSE**: _____ **FREQUENCY**: _____

MEDICATIONS ALLERGIES: ☐ NONE _____

OTHER ALLERGIES: ☐ NONE _____

WOULD YOU LIKE A SLEEP EVALUATION? ☐ YES ☐ NO **HAVE YOU HAD AN ALLERGY TEST**? ☐ YES ☐ NO

MEDICAL HISTORY: ☐ NON-CONTRIBUTORY

☐ DEPRESSION • ☐ KIDNEY DISEASE • ☐ HEART DISEASE • ☐ ANEMIA • ☐ DIABETES • ☐ HIGH BLOOD PRESSURE

☐ SEIZURES • ☐ ASTHMA • ☐ THYROID DISEASE • ☐ CANCER: (TYPE) _____ • ☐ OTHERS: _____

SURGICAL HISTORY: ☐ NON-CONTRIBUTORY

TYPE: _____ **DATE**: _____

FAMILY HISTORY: ☐ NON-CONTRIBUTORY

☐ DEPRESSION • ☐ HIGH CHOLESTEROL • ☐ HEART DISEASE • ☐ DIABETES • ☐ HIGH BLOOD PRESSURE • ☐ ASTHMA

OTHERS: _____

SOCIAL HISTORY: ☐ NON-CONTRIBUTORY

SMOKER: ☐ YES ☐ NO **# PACKS PER DAY**: _____ **SUBSTANCE ABUSE:** ☐ YES ☐ NO **ALCOHOL ABUSE:** ☐ YES ☐ NO

OFFICE USE ONLY:

WT_____ HT_____ TEMP_____ RR_____ HR_____ O2_____ BP_____

Consents for DOCS Medical Inc. and its subsidiaries (DOCS of CT, DOCS Urgent Care, Zen Health and Wellness, Epic Family Physicians, Continuum Medical Group and Urgent Care Center), hereby referred to as DOCS Medical Inc.

AUTHORIZATION OF TREATMENT

I consent to providers and licensed professionals (including but not limited to Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, Respiratory Therapists and Medical Assistants) to provide all medical services permitted by their training and licensure, including telehealth services for myself or my dependent. I voluntarily consent to the administration and costs of medical and surgical procedures for both in-person and virtual care for myself or my dependent.

ASSIGNMENT OF INSURANCE BENEFITS/GUARANTEE OF PAYMENT

I authorize payment directly to DOCS Medical Inc., for all benefits payable to me. I understand that I am financially responsible and agree to pay all charges that are not paid by or billed to my insurance or any third-party payer. I understand that I must pay in full today for all services rendered for both in-person and virtual visits unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-payments, co-insurance, or deductible for services. I understand all services, both in-person and virtual, rendered are non-refundable under any circumstance. I understand that if I do not pay within 90 days upon receiving my billing statement; my account will be transferred over to a collection agency working on behalf of DOCS Medical Inc.

COVID TESTING/TREATMENT

As the pandemic draws to a close the government is no longer paying for COVID-19 testing. Many insurance carriers will no longer cover surveillance testing, which is testing used for public health or social purposes such as employment (return to workplace), education, travel, or entertainment. In these cases, insurers will refer you to either a free testing site located on their websites or at home testing kits. In line with the government and insurance policies, payment will be expected at the time of service for surveillance testing. Other than patients requiring surveillance testing, patients requesting COVID-19 testing will be seen by a physician or qualified healthcare professional for COVID-19 evaluation/ treatment, testing/evaluation/treatment will be based upon medical necessity. Cost-sharing will be according to the member's benefit plan. You will be responsible for any copay, coinsurance, deductible or out-of-network costs.

FLU VACCINATION

By signing this form I understand that if I'm receiving a flu shot I consent to having my insurance billed for all applicable in accordance to my insurance guidelines. This includes but is not limited to patient education, consulting, administration fee, and visit codes. Cost-sharing will be according to the member's benefit plan. You will be responsible for any copay, coinsurance, deductible or out-of-network costs.

TELEMEDICINE CONSENT (DOCS NOW)

Patients can receive care through DOCSNow, our telemedicine platform. RECORDS: Telecommunications with patients will be recorded and stored on the HIPAA compliant secure platform approved for telecommunications (not available on patient portal/healow).

TELEMEDICINE INFORMATION: The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with synchronous video and audio. Medical examinations (limited to device capabilities) will be performed using the TytoCare, FDA filing Regulation Number: 21 CFR 870.1875.

ACCESS: The patient accepts that he/she needs access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telemedicine appointment. If you are doing your telemedicine visit from a DOCS Location a device will be provided.

PATIENT RIGHTS: . By signing this form, I understand that all the laws that are protecting my privacy of medical history or information is also applied to telemedicine practices. I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures and can ask questions related to telemedicine appointments and technical requirements for telecommunication in writing. I understand that I can be charged the additional fees that my insurance does not cover. I accept that I authorize health care professionals and use telemedicine for my treatment and diagnosis. To opt out please go online and submit the opt out form https://docsmedicalgroup.com/docsprimarycare/consentform

RELEASE OF RECORDS

I authorize DOCS Medical Inc. and its subsidiaries to release (verbal or written) confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employer purposes), or other health care operations which may be liable to me or my practitioner(s) for changes in treatment, for quality management, utilization review, transfer, and follow-up purposes.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by the person legally responsible for the patient's medical decisions relative to the treatment situation. I hereby acknowledge that DOCS Medical Inc. has provided me with a copy of its notice of privacy policies that describe how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact DOCS Medical Inc. Administration Directors at 203-874-3682 or by e-mailing contact@DOCSofct.com. I also understand that I am entitled to receive updates upon request when DOCS Medical Inc. and its subsidiaries amends or changes its notice of privacy practices material in any way.

PRIVACY POLICY The department of health and human services has established a "privacy policy" to help ensure that personal information is protected for your privacy. The privacy rule was also created in order to provide a standard for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical information. We strive to always make reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary to only those we feel are in need of your health care information, and information regarding treatment, payment, or health care operations in order to provide health care that is in your best interest. We also want you to know that we support your access to your personal medical records.

We may have indirect treatment relationships with you such as laboratories that only interact with physicians and not patients. We may have to disclose personal health information for purposes of treatment, payment of health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information; however, this must be in writing. Under the law, we have the right to refuse to treat you, should you choose to refuse disclosure of your personal health information (PHI) if you chose to give consent at a future time you may request to refuse all or part of your phi. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy note.

REFERRALS/ORDERS

If you are a patient who was referred from DOCS Medical Inc. offices and its subsidiaries, you hereby duly acknowledge that you were given the option to choose a facility/laboratory of your choice at the time of referral and/or order. DOCS is not responsible for lack of insurance coverage or in/out of network status of practices you are referred to.

LABORATORY

All laboratory testing done in DOCS physician office laboratory (POL) and other health care facilities are subject to government regulations called the Clinical Laboratory Improvement Act (CLIA). According to the regulations, the Centers for Medicare & Medicaid Services (CMS) oversees all laboratory testing done on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. I authorize DOCS to disclose the protected health information, my lab results, via patient portal/Healow. I understand and agree that the services provided by DOCS and the tests results from the lab will be maintained as confidential, protected health information by DOCS as required by federal and state law.

PATIENT PORTAL/HEALOW CONSENT FOR NOTIFICATION OF TEST RESULTS

I give permission to DOCS Medical Inc. and its subsidiaries to share my health information through electronic communication to me, Healow (Patient Portal), in which I provided my information to create the account. I understand that I can revoke this access and stop communications by opting out through Healow (Patient Portal). The Healow patient portal is maintained by eclinicalworks.

ELECTRONIC HEALTH EXCHANGE

Health Information Technology Exchange of Connecticut, Consumer Authorization and Consent Policy 3 (2011) - HITE-CT's consumer authorization and consent policy gives patients the option to opt out of having their PHI disclosed through HITE-CT. If a patient has not opted out, HITE-CT will disclose all non-sensitive PHI for the purposes of treatment, payment and health care operations as permitted by HIPAA, unless the patient and provider have agreed upon a specific restriction on disclosure. Sensitive PHI is PHI that is "subject to heightened confidentiality requirements in compliance with all federal and state laws as amended from time-to-time (HIV, substance abuse and mental health records)." Patients must specifically authorize disclosures of sensitive PHI. A patient's opt-out of HITE-CT is global, which means that no PHI will be disclosed to any party by HITE-CT, except as required by law (such as public health reporting requirements, etc.). However, even if a patient has opted out, HITE-CT may allow for disclosures of PHI in emergency treatment situations, but such disclosures will be audited strictly to make sure that there was a legitimate emergency requiring disclosure. To opt out please go online and submit the opt out form
https://docsmedicalgroup.com/docsprimarycare/consentform

PRIMARY CARE

I consent to the treatment that will be provided by the providers and licensed professionals (including but not limited to Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, Respiratory Therapists and Medical Assistants). I understand that a medical record will be prepared and maintained about me by the DOCS Primary Care Team, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by DOCS Medical for that purpose. I understand that I will need to complete my annual physicals and wellness visits with DOCS Primary Care every 12 months. I understand that DOCS Primary Care is a participating provider in PCMH (Patient Centered Medical home) and ACO (Accountable Care Organization) programs, and I consent to being automatically enrolled in those programs in accordance with my insurance policies.

PCMH AND ACO

DOCS Medical has earned the distinction of becoming a **Patient Centered Medical Home (PCMH)** and an **Accountable Care Organization (ACO)**. PCMH is health care centered on the patient. It is a partnership between the patient and the doctor. ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

DOCS leads a team of health care professionals in a medical practice committed to improving the patient's overall health and to helping the patient reach their health goals. The patient's health team will consist of a physician, specialty physicians, dieticians, nurses, medical assistants, case managers, and others depending on the patient's needs. DOCS will put the right team in place for the patient.

Patient or Parent/Guardian RESPONSIBILITY:

- Tell us what you know about the patient's health and illnesses, and what the needs and concerns are.
- Take an active part in planning care and following that plan. Inform us if you are unable to meet the goals defined.
- Tell us about medications being taken and ask for refills in a timely manner. Ask for your refills at the time of your office visit. Otherwise, give the office staff at least 24 hours' notice to complete refills.
- Seek our advice before arranging to see other physicians or other health care professionals. Keep us informed of the recommendations they make.
- Learn about wellness and prevention for your family, as we believe a healthy family produces a healthy patient.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Know what insurance you have, as well as what it covers. We appreciate and expect co-pays to be paid at the time of service.

Provider RESPONSIBILITY:

- Respect you as an individual – we will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability or sexual orientation.
- Provide safe, quality care to the patient in the appropriate language selected by the patient.

- Respect your privacy – your medical information will not be shared with anyone else unless you give permission or as required by law.
- Provide 24-hour access to our health care team.
- Help you plan goals that meet your needs and discuss these goals with you to improve your health and help prevent persistent health problems.
- Discuss the most appropriate tests and procedures you may need.
- Coordinate and arrange your care among other health care professionals and provider systems via linkage agreements and referrals.
- End every visit with a clear understanding of the expectations, treatment goals, and future plans.

BEHAVIORAL HEALTH

I consent to the treatment that will be provided by the providers and licensed professionals (including but not limited to Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, and Medical Assistants). I understand that a medical record will be prepared and maintained about me by the DOCS Behavioral Health Team, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by DOCS Medical for that purpose. I understand that I will need to complete my mental health assessments and adhere to all schedule appointments. I understand that DOCS Behavioral Health is a participating provider in PCMH (Patient Centered Medical home) and ACO (Accountable Care Organization) programs, and I consent to being automatically enrolled in those programs in accordance with my insurance policies.

Phone Call Reminders:

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By signing this form, you consent to receive pre-recorded messages, e-mail, patient portal notifications and phone calls from DOCS.

Text Messages:

There are times we may be capable of sending text messages. By signing this form, you consent to receive text messages from DOCS on your cell phone number provided to us.

CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS:

I understand that my healthcare information is protected. I understand that, for us to leave detailed messages containing specific medical or billing related information on my voice mail or answering machine, I need to give permission for DOCS staff to do so.

Consent for Leaving Messages

I give my permission for messages to be left on my phone number(s) below:

Cell # _____ **Home #** _____ **Work #**_____

I prefer not to have voice mail messages from the clinic, regarding the following *(for yes/no options, please place your initials next to your selection):*

- **Appointment Reminders/Changes**: Yes _____ No _____
- **Account Payments/Balances:** Yes _____ No _____
- **Cost Estimates**: Yes _____ No _____
- **Needed Treatment/Completed Treatment**: Yes _____ No _____

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law, we are permitted, and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form. The name(s) listed below are family members or friends to whom I grant permission for DOCS MEDICAL INC providers or representatives at our clinic to verbally discuss my care using their best judgment and grant them permission to disclose medical information that is relevant to my care or relevant for payment.

Yes _____ ***No*** _____

NAME	RELATIONSHIP	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Regarding the following: Appointment Reminders/Changes Account Payments/Balances Cost Estimates/Needed Treatment/Completed Treatment, it will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

MARKETING AND SURVEY'S- I consent to allow DOCS Medical and its subsidiaries to send me marketing emails and surveys. You may opt out of these communications at any time. To opt out please go online and submit the opt out form https://docsmedicalgroup.com/docsprimarycare/consentform

By Signing Below, I consent and have read all outlined above, I understand that if I have questions regarding any Docs consents and policies, I may contact DOCS Medical Inc. Administration Directors at 203-874-3682 or by e-mailing contact@DOCSofct.com. To opt out please go online and submit the opt out form https://docsmedicalgroup.com/docsprimarycare/consentform

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

PARENT OR GUARDIAN SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____