Office of Paul H. Deutsch M.D., R.Ph., LLC

86 New London Turnpike
Norwich, CT 06360
Phone: 860 889-6967
Fax: 860-885-1033

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

New Patient Registration Form

Welcome to our practice. Please print all information.

SECTION 1: PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security #: _____ DOB: _____ Gender: M / F

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Legally Separated

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different than above): _____

Primary Phone #: _____ Alternate Phone #: _____

Previous or Referring Provider: _____

SECTION 2: GUARANTOR INFORMATION /RESPONSIBLE PARTY *(If different from the patient)*

Guarantor's Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone #: _____ Social Security #: _____

SECTION 3: EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Emergency Contact Address: _____

Emergency Contact Phone: _____ Relationship _____

I give consent to share data with external entities, please select

__ Send __ Receive __ Opt-Out

Race: ◯ Asian ◯ African American ◯ Hispanic ◯ American Indian or Alaska Native

◯ Native of Hawaii/Pacific Islander ◯ White ◯ Other (Please specify): _____

Ethnicity: ◯ English ◯ Spanish ◯ French ◯ Dutch ◯ Chinese ◯ Greek ◯ Hindi ◯ Russian

◯ Portuguese ◯ German ◯ Other (Please specify): _____

Email Address: _____

SECTION 4: EMPLOYMENT

Employment Status: ◯ Full Time ◯ Part Time ◯ Not Employed ◯ Retired ◯ Active Military ◯ Full-time Student ◯ Part-time Student

Employer: _____ Phone Number: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORK OR AUTO RELATED INJURY? YES / NO / UNDETERMINED
If yes or undetermined, please ask receptionist for addition paperwork.

SECTION 5: SUBSCRIBER INFORMATION *Please present insurance card(s) to receptionist for copying.*

PRIMARY *(Self/Significant Other /Parent or Guardian)*	**SECONDARY** *(Self /Significant Other /Parent or Guardian)*
Insurance Name: _____	Insurance Name: _____
Effective Date: _____	Effective Date: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Subscriber S.S. #: _____	Subscriber S.S. #: _____
I.D. #/Policy #: _____	I.D. #/Policy #: _____
Group/Plan #: _____	Group/Plan #: _____

If Medicare is secondary, circle reason: *Working Spouse has insurance Veteran Disabled*

Other: _____

SECTION 6: AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I have been provided a copy of the Paul H. Deutsch M.D., R.Ph., LLC Financial Policy. I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements promptly upon their presentation unless credit arrangements are agreed upon in writing.

I authorize payment of insurance benefits be made directly to Paul H. Deutsch M.D., R.Ph., LLC for services rendered. I authorize Paul H. Deutsch M.D., R.Ph., LLC to release any medical information necessary to process claims for payment.

I acknowledge I have received Paul H. Deutsch M.D. R.Ph., LLC Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information and how I can access this information. I understand I am entitled to receive updates upon request if Paul H. Deutsch M.D., R.Ph., LLC Notice of Privacy Practices is amended or changed in a material way. I also understand if I have question or complains I may contact the Privacy Officer at 860-889-0025.

Patient/Guarantor Signature _____ **Date:** _____
This authorization will remain in effect unless rescinded in writing by the above signed.

Paul H. Deutsch, MD, RPh, LLC
BOARD CERTIFIED INTERNAL MEDICINE
86 NEW LONDON TPKE
NORWICH, CT 06360
860-889-6967

Permission to Communicate

	By initialing this box , I am revoking all previous Permission to Communicate forms.

Patient Name: _____ **Date of Birth:** _____

I authorize Paul H Deutsch, MD RPh, LLC to share my protected health information with family members or others as designated by me below. This permission is NOT an authorization to release medical records, or a consent to treatment.
This permission also authorizes Paul H Deutsch, MD, RPh, LLC to communicate with authorized persons by phone (including voice messages), in person, or by other means acceptable by Paul H Deutsch, MD RPh, LLC.

1.) Name:_____

Phone Number: _____ **Relationship to Patient:**_____

2.) Name: _____

Phone Number: _____ **Relationship to Patient:**_____

3.) Name:_____

Phone Number: _____ **Relationship to Patient:**_____

I understand that I am under no obligation to provide Paul H Deutsch, MD RPh, LLC with this Permission to Communicate, and that Paul H Deutsch, MD RPh, LLC will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form. I understand that I may revoke this Permission if I so choose. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form, or by notifying Paul H Deutsch, MD RPh, LLC in writing of my revocation. Communications should be sent to : Paul H Deutsch, MD RPh, LLC at 86 New London Turnpike, Norwich, CT 06360, Attention: Privacy Officer.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Patient: _____ **Date:** _____

Clinical Information

Welcome to our practice. Please print all information.

Patient Name: _____ DOB: _____

Primary Pharmacy:

_____ City: _____

Childhood Illness:	¨ Measles ¨ Mumps ¨ Rubella ¨ Chickenpox ¨ Rheumatic Fever ¨ Polio	
Immunizations and dates:	¨ Tetanus	¨ Pneumonia
	¨ Hepatitis	¨ Chickenpox
	¨ Influenza	¨ MMR *Measles, Mumps, Rubella*

List your prescribed drugs and over-the-counter drugs, such as vitamins and supplements

Name the Drug	Strength	Frequency Taken

Medical History: Please list conditions and date diagnosed

Medication Allergies

Drug Name	Reaction You Had

Patient Name: DOB:

Surgeries: Have you ever had any of the following?

Screening Procedures	*Date*	*Location/Result*
Colonoscopy:		
Mammogram:		
Pap Smear:		
Bone Density:		
Other:		
Other:		

Other Surgeries:	*Date*	*Location*

Other hospitalizations: Please Do Not Include Hospitalizations for Outpatient Surgeries

Year	*Reason*	*Hospital*

Family History

Family Member	Alive	Deceased	Age	Conditions:
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Siblings				
Children				
Other Family History				

How many siblings do you have? (please indicate brothers and sisters separately)

How many children do you have? (please indicate sons and daughters separately)

Patient Name: DOB:

Social History

Do you use tobacco?	Y / N	If yes, what form and how much?	
How long have you used tobacco? Do you vape or use e-cigarettes?	yrs.		
		If no, did you ever quit?	
		When did you quit?	
Do you have smoke alarms?			
Do you drink alcohol?	Y / N	If yes, how many drinks in 1 week?	
Do you wear you seatbelt?	Y / N		
Do you drink caffeine?	Y / N	If yes, how many 12oz servings/day?	
Do you use recreational drugs? Do you use medicinal marijuana?	Y / N		
Do you exercise?	Y / N	How often per week?	
Do you have frequent falls?	Y / N		
Do you have a history of depression?	Y / N	Do you see a psychiatrist/psychologist?	
Do you have vision loss?	Y / N	Do you wear glasses or contacts?	Y / N
Do you have hearing loss?	Y / N	Do you wear hearing aids?	Y / N
Have you traveled outside of the U.S?	Y / N	Countries:	
What do you do for work?			
Occupational Exposure?			

Domestic Abuse

Who do you live with?					
Do you feel safe in your home?				Y / N	Please explain all no answers:

Sex: If Applicable

Are you sexually active?			Y / N	

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?	Y / N

I agree to comply with urine and/or blood testing to document proper use of medication

Patient Signature *Date*

Are you experiencing any of the following symptoms?					
Y / N	**CONSTITUTIONAL**	**Y / N**	**BREAST**	**Y / N**	**MUSCULOSKELETAL**
	Fatigue		Discharge from nipple		Neck Stiffness
	Weight loss		Breast tenderness		Neck pain
	Weight gain		Breast mass		Back stiffness
	Fever				Back pain
	Chills	**Y / N**	**GASTROINTESTINAL**		Joint swelling
Y / N	**EYES**		Loss of appetite		Joint pain
	Double vision		Trouble eating		Limitation of joint movement
	Blurred vision		Abdominal pain		Muscle pain
	Sensitivity to light		Nausea	**Y / N**	**SKIN**
	Reduced vision		Vomiting		Skin rash/ lesions
	Eye redness		Change in bowel habits		Dry itchy skin
	Eye itching		Diarrhea		Nail problems
	Eye pain		Constipation		
			Blood in stool	**Y / N**	**NEUROLOGIC**
Y / N	**EARS**	**Y / N**	**GENITAL / URINARY**		Headache
	Ear discharge		Pain with urination		Dizziness
	Ear pain		Blood in urine		Lightheadedness
	Tinnitis		Discharge		Fainting
	Hearing loss		Dribbling of urine		Weakness
Y / N	**NOSE / THROAT**		Frequent urinating at night		Numbness/Tinglin g
	Nasal congestion		Testicular mass		Tremor
	Nasal discharge		Testicular pain		
	Postnasal drip		Problems with erections	**Y / N**	**PSYCHIATRIC**
	Sneezing	**Y / N**	**HEMATOLOGIC LYMPHATIC**		Difficulty sleeping
	Runny nose		Swollen glands		Mood Swings
	Sore throat		Lymph node tenderness		Feeling Anxious
	Bleeding gums		Anemia		Feeling Depressed
	Hoarseness		Bruise easily		Confusion
Y / N	**RESPIRATORY**		Bleed easily		Memory Loss
	Shortness of breath			**Y / N**	**ENDOCRINE**
	Cough				Frequent hunger
	Wheezing				Drinking a lot
	Pain with breathing				Frequent urination
Y / N	**CARDIOVASCULAR**				Enlarged thyroid
	Chest pain				Intolerant of heat
	Palpitations				Intolerant of cold
	Irregular heart beat				

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Patient Financial Policy (effective 06/2024)

Paul H. Deutsch, MD, RPh, LLC is committed to providing information and quality services for all of our patients. We encourage our patients to take an active role in their care, interacting with our providers, nurses and ancillary staff. As part of our commitment to you, we feel it is important that you understand your financial responsibility. Our policies are listed below. If you have any questions, please ask one of our staff to direct you to the Business Officer for assistance.

PAYMENT AT TIME OF SERVICE/ADDITIONAL CHARGES (charges that may be billed after you leave office)

We expect payment at time of service, regardless of insurance status. If you do not have insurance card at time of service, you may either pay in full or reschedule your appointment. If you have insurance, you will be required to pay your copay, or coinsurance percentage, and any unmet deductible amount the day of the visit. The only exceptions to this are patients who have Medicare and Medicaid combined, or who have dual insurance plans that are contracted with us and have met all deductibles.

Please be advised that some charges may not appear on your fee ticket when checking out, and are subject to change upon review. These may include, but are not limited to: ekg, injections, vaccines, or other ancillary service charges. Because some services may require additional tests or follow up, we cannot ensure that all the charges are indicated.

SELF PAY – NO INSURANCE

If you do not have insurance, you will be expected to pay for your visit at the time of service. We will require payment for the office visit in the form of check, cash or credit card, immediately following your visit at check-out. Additional charges may be assessed at checkout for any ancillary services. If you are unable to make this deposit, your appointment will be rescheduled. The deposit also applies if you are unable to present your insurance at time of service.

If you request an appointment and have an unpaid balance on your account, you will be referred to our Billing Manager to discuss options for payment. Our payment plans are based on financial need and require the doctor's approval.

MEDICAID

Paul H. Deutsch, MD, RPh, LLC is not currently accepting new Medicaid patients. Existing Medicaid patients are required to bring your insurance card and photo ID to each visit.

MEDICARE

Patients receiving Medicare benefits are required to pay their copay at each visit. Any service not covered by Medicare is your responsibility.

PRIVATE INSURANCE

Paul H. Deutsch, MD, RPh, LLC will bill most primary insurance carriers. Payments for copays or deductibles are expected at time of service. If you cannot pay for your portion, you will be referred to our billing manager for payment arrangements. You will be responsible for any amounts where we were not given corrected or updated information by you at the time of service. We will bill secondary insurance plans as a courtesy.

DOT PHYSICALS

These visits and related charges are not covered by insurance. There is a $150.00 fee, payable at time of service. These visits cannot be combined with your yearly Wellness Visit (Physical Exam).

NON-COVERED SERVICES
Some treatments are not covered by insurance and are expected to be paid at the time of service. Because individual policies vary, it is not possible for our staff to know exactly what your policy will cover. We encourage patients to contact their insurance carrier to inquire about coverage, deductibles and copay amount prior to their visit.

REFUNDS
At times, refunds or credits are created. If you receive indication from your insurance company that a possible refund is due, please contact our billing manager at 860-889-0025.

NO SHOW POLICY
Any patient who fails to arrive for a scheduled appointment, without canceling the appointment at least 24 hours prior to the scheduled time OR arrives more than 30 minutes late is considered a "no-show". A patient who no-shows three times in a 12-month period will be dismissed from the practice. A patient that no-shows a New Patient Appointment will not be rescheduled.
If you have any questions regarding your financial responsibility to Paul H. Deutsch, MD, RPh, LLC, please do not hesitate to contact our Business Officer at 860-889-6967 or Billing Manager at 860-889-0025.

Signature _____ Date _____

INSURANCE ASSIGNMENT, AUTHORIZATION AND NON-COVERED BENEFITS WAIVER

I hereby assign benefits to be paid directly to Paul H. Deutsch, MD, RPh, LLC, and authorize the practice to furnish information regarding my diagnoses to my insurance carrier. I understand that I am responsible for any amount not paid by my insurance.
I understand certain tests or procedures are not a covered benefit within my insurance plan or policy. I know that if I have any questions regarding what is or is not covered under my insurance plan or policy, I should contact my insurance carrier prior to having any test/procedure performed. If I have a test/procedure performed that is not a covered benefit, I understand I am responsible for payment in full for incurred charges.

Signature _____ Date _____

Printed Name _____ DOB _____

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Notice of Privacy Practices for Protected Health Information (PHI)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: May 2024

The practice of **Paul H Deutsch, MD, RPH, LLC** is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, if we need to speak with you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

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Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have the right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes, if at the time, an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to complete incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____
Print Name

_____ _____
Patient (or patient representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgment
- o Other (Please Specify)

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*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

Office of Paul H. Deutsch M.D. R.Ph., LLC

Secure Messaging

Paul H. Deutsch MD RPh LLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Print Sign Date