All Island Medical Associates, P.C.

Sareth Pinnamaneni, MD, F.A.A.F.P.
1500C Ocean Avenue
Bohemia, NY 11716
Tel: 631-589-7787 Fax 631-589-3908

Name_____ Today's Date_____
Address _____SS# _____DOB_____
City _____State_____ Zip_____
Phone(home)_____(work)_____(cell)_____
Sex ( )M ( )F Marital Status ( )married ( )divorced ( )single ( )widowed ( )other
Occupation_____Employer_____
Address_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name_____ SS#_____
Relationship to Patient_____
Street_____City_____State/Zip_____
Home Phone_____ Work Phone_____

PATIENT EMERGENCY CONTACT

Contact Name_____Relationship_____
Home Phone _____Work_____ Cell_____

AUTHORIZATION FOR PAYMENT
I request payment of this claim and if the payer accepts assignment then the payment should go directly to the physician for services rendered.

AUTHORIZATION FOR MEDICARE PAYMENT
I request that payment of authorized Medicare benefits be made to the physician on my behalf for any services furnished to me.

Patient/Parent signature _____Date_____

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Dear Patient:

As per HIPPA rules and regulations you are required to inform this office how you wish us to communicate with you in regards to your Personal Health Information. At times we may need to contact you to confirm your appointment, schedule tests, return your phone call or give you results of labs, x-rays, scans or consultations. We are required to follow your written instructions specifically, except where we feel following the instruction would be detrimental to your health or in case of emergency. Please be very specific as to how we are to reach you, where we can leave messages and with whom.

You may discuss my Personal Health Information with:

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

You may contact me at the following phone numbers:_____

_____

Please initial all that apply

_____You may leave a message

_____You may not leave a message

I have received a copy of the Notice of Privacy Practices.

_____

Signature of Patient (or Personal Representative) Date

_____

Printed name of patient (or personal representative) relationship to patient

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Attention Patients:

Payment Policy and Patient Responsibility thank you for choosing me as your primary care provider. I am committed to providing you quality and affordable health care. Please read the following policies and sign below in the space provided. A copy will be provided to you upon your request.

1) **INSURANCE**-Knowing your insurance billing information and benefits is your responsibility. Please contact your insurance company with any questions you may have regarding eligibility and covered services.
2) **CO-PAYMENTS**-All co-payments are patient responsibility and must be paid at the time of service. This arrangement is part of the contract between you and your insurance company.
3) **DEDUCTIBLES & CO-INSURANCE**-All deductibles and co-insurance amounts are patient responsibility and will be billed to you after insurance has processed the claim. This arrangement is part of the contract between you and your insurance company.
4) **NON-COVERED SERVICES**-Please be aware that some or all of the services provided to you during your visit may not be covered by your insurance company. Any non-covered charges are patient responsibility.
5) **PROOF OF INSURANCE**-All patients must complete the patient registration form before receiving any services through our facility. We also require a copy of a valid photo ID, such as state license, and a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim in full.
6) **CLAIMS SUBMISSION**-Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims to both primary and secondary insurance. Some insurance companies require patients to submit information directly, and if so, this is your responsibility. Please be aware that the balance of the claim is your responsibility if your insurance company does not pay.
7) **COVERAGE CHANGES**-It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failing to do so may result in unpaid claims and you may be responsible for the balance of the claim in full.
8) **UNINSURED/SELF-PAY PATIENTS**-If you are seeking medical services at our facility and do not have insurance, a fee is required for each visit - $175.00 for new patient appointments and $125.00 for established patient appointments.
14) **STATEMENTS**-Patient statements are mailed monthly and payment is required upon receipt of your statement. If your account is over 30-days past due and arrangements for payment have not been made, you will receive a letter stating that you

have 30 days to pay your account in full. Partial payments will be accepted after satisfactory arrangements have been made with our billing department. If balances remain unpaid, we may refer your account to a collection agency. Accounts with small balances under $3.00 will not have statements sent and will be collected at the patient's next visit.

15) **RETURNED CHECKS**-If you pay with a check and your check is returned, your account will be charged a $25.00 fee which you will be responsible for along with the amount of the payment.

16) **MISSED, CANCELLED, & RESCHEDULED APPOINTMENTS**-We require a 24-hour notice on all appointments cancellations and reschedules. Our policy is to charge a $25.00 fee billed directly to the patient or responsible guardian for missed appointments and failure to cancel more than 24 hours in advance. If you fail to keep an appointment due to unforeseen circumstances, please discuss this with our office manager or billing department.

17) **HARASSMENT**-This is a private practice in Family Medicine where we strive to create a pleasant environment for all patients and staff. We understand that there are times when patients may be frustrated, and we will make every attempt to assist you. However, this practice will not tolerate physical abuse, verbal abuse, or harassment of any kind, under any circumstance. Abuse or harassment in any form is grounds for immediate discharge from the practice.

18) **PAIN MANAGEMENT**-Our providers do not treat or manage chronic pain. The American Pain Society defines "chronic pain" as pain that lasts more than 6 months, is ongoing, is due to non-life-threatening causes, has not responded to current available treatment methods, and may continue for the remainder of a person's life. If you are suffering from chronic pain, your provider will discuss with you other options for seeking treatment.

"I acknowledge that I have read, understand, and will follow all policies and responsibilities stated above. I acknowledge that I am financially responsible for all charges for services rendered. If it becomes necessary to effect collections of any amount owned on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I also hereby authorize the All Island Medical Associates, PC to release information necessary to secure payment."

_____ Patient Name (Print)

_____ _____

Patient or Legally Authorized Representative Signature Date

_____ _____

Legally Authorized representative (Print) Relationship to Patient

Triple i / CliniForms

Patient Registration

Name _____ SS# _____

General Medical Information

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Do you smoke? ❑ No ❑ Yes ❑ Cigarettes ❑ Pipe ❑ Cigars No. of years _____ How much? _____

Interested in stopping? ❑ Yes ❑ No

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces/beers per day? _____

Do you regularly drink coffee? ❑ Yes ❑ No How many cups per day? _____

Are you under a lot of pressure at work? ❑ Yes ❑ No Please describe: _____

Personal Medical History

Have you ever had any of the following (check all that apply):

❑ Chest pain/pressure/tightening _____	❑ Asthma _____	❑ Kidney disease _____
❑ Hypertension _____	❑ Dizzy spells _____	❑ Shortness of breath _____
❑ Heart attack _____	❑ Cancer _____	❑ TB/Lung disorder _____
❑ Stroke _____	❑ Diabetes _____	❑ Ulcers _____
❑ Headaches _____	❑ Arthritis _____	❑ Skin disorders _____
❑ Glaucoma _____	❑ Difficulty hearing _____	❑ Hepatitis _____
❑ Allergies or Eczema _____	❑ Glaucoma _____	❑ Cataracts _____
❑ Depression _____	❑ Memory loss _____	❑ Digestive problems _____
❑ Blood in stool _____	❑ Hemorrhoids _____	❑ Frequent urinary infections _____

❑ Other: _____

Immunizations

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Rubella _____

Hepatitis _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Eczema / psoriasis	❑	❑	❑	❑	❑	❑
Heart attack / stroke	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Hay fever	❑	❑	❑	❑	❑	❑

Miscellaneous Notes

_____

_____

_____

_____

_____

Name _____

PATIENT REGISTRATION

Name _____ SS# _____

Street Address _____ Date of birth _____ Marital status: S M W Sep D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Referred by _____

Spouse's name _____

Spouse's employer / address _____

Emergency contact _____ Tel# _____ Relationship _____

PATIENT EMPLOYER INFORMATION

Employer name _____ Tel# _____

Employer street address _____ City / State _____ Zip _____

Patients occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel# _____

Street Address _____ City / State _____ Zip _____

Relationship to patient _____

INSURANCE

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

MISCELLANEOUS NOTES

_____

_____

_____

_____

_____

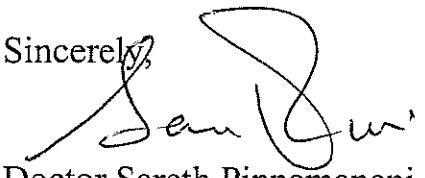
Attention All Island Medical Associates Patients:

As of January 1st, 2022, our office policies have changed. Patients on non-controlled prescriptions will need to be seen every 90 days for an in-office appointment. All those on a controlled prescription will need to be seen every other month. There are no exceptions to this policy. The policy has been implemented to better patient care.

By signing below, you are agreeing that you have been made aware of the updated policy. A copy will remain in your record, you may obtain a copy at any time.

Thank you for allowing me to continue to care for your medical needs. Should you have any questions please contact us in office.

Sincerely,



Doctor Sareth Pinnamaneni, MD

Patient Name: _____ Date: _____

Patient Signature: _____

December 20, 2021

ARE YOU FEELING DEPRESSED?

Many people think of depression as simply being sad. But it's more than sadness. It's a combination of multiple symptoms. Fill out the questionnaire below, and take it with you to your next appointment. This is not a complete diagnostic tool, so be sure to talk with your healthcare provider about all of your depressive symptoms. It's important to discuss potential treatment options that may help you.

The Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you circled **any** problems on this questionnaire so far, mark how **difficult** these problems have made it for you to do your work, take care of things at home, or get along with other people.

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

ADD COLUMNS _____ + _____ + _____

TOTAL _____

For healthcare professionals:
Because this questionnaire relies on patient self-report, all responses should be verified by the clinician. A definitive diagnosis should be made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Be sure to exclude the effects of a substance or medical condition that may better account for the symptoms.

Takeda

Lundbeck