UB|MD INTERNAL MEDICINE PRIMARY & SPECIALTY CARE

NEW PATIENT HEALTH HISTORY

Please **take time** *to complete the following information for your medical chart. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.*
Please address EVERY section

PATIENT NAME	BIRTH DATE / /	TODAY'S DATE / /

REASONS FOR YOUR VISIT *(list current symptoms)*

1.	3.
2.	4.

PHARMACY INFORMATION

Please provide accurate pharmacy information so that we can fill/refill medications you may need.

Local Pharmacy Name: _____

Pharmacy Street Address: _____

_____

Pharmacy Phone #: _____

Do you use a **Mail Order Pharmacy**? Y / N

If yes, **Name of Mail Order Pharmacy**: _____

MEDICATIONS

Include all current medications including prescriptions, infusions, and over-the-counter herbal/vitamins/supplements *IF NOT ON ANY MEDICATIONS PLEASE CHECK "NONE"*

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT TAKEN?	REASON FOR MEDICATION	PHYSICIAN PRESCRIBING THIS MEDICATION
EX: Aspirin	**81 MG**	**Daily, Twice a day, Bedtime etc.**	**Stroke Prevention**	**Dr John Doe**
☐ **NONE**				

PATIENT NAME	BIRTH DATE / /

ALLERGIES *Include medications, food, latex, adhesive, chemicals, insects, etc. IF NO KNOWN ALLERGIES PLEASE CHECK "NONE"*

ITEM	TYPE OF REACTION
☐ **NONE**	

MEDICAL HISTORY

Condition	Date-of-onset	Hospitalized	Specialist
☐ **NONE**		(circle)	
1.		Y / N	
2.		Y / N	
3.		Y / N	
4.		Y / N	
5.		Y / N	
6.		Y / N.	
7.		Y / N	
8.		Y / N	

Please use a separate sheet of paper to list any others

SURGICAL HISTORY Please list ALL *Surgeries- Procedures- Hospitalizations* ~ ***INCLUDE DATE*** ~

Procedure/Reason/Diagnosis	Date	Procedure/Reason/Diagnosis	Date
☐ **NONE**		5.	
1.		6.	
2.		7.	
3.		8.	
4.		Please use a separate sheet of paper to list any others	

PATIENT NAME	BIRTH DATE / /

IMMEDIATE FAMILY HISTORY

(For example, diabetes, high blood pressure, heart disease, stroke, cancer, etc.)

Please complete the following information on your biologic relatives

IF DECEASED, PLEASE INCLUDE AGE AT TIME OF DEATH

Family Members	Living	Deceased	Age	Sex	Chronic Condition(s) - If deceased, Cause of Death and age at time of death
Father	☐	☐			
Mother	☐	☐			
Brothers or Sisters:					
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
Children:					
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
Other (Uncles, Aunts, etc.):					
	☐	☐		M F	
	☐	☐		M F	

PATIENT NAME	BIRTH DATE / /

PERSONAL HISTORY

Please complete the following information about yourself.

Current occupation: _____

Have you ever worked in a job where you were exposed to hazardous environment or chemicals? Y / N

Education completed:

☐ Grade: _____ ☐ High School ☐ College: _____ years, degree/major _____

☐ Post-graduate:_____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____ What are their ages? _____

Personal habits: *(please check all that apply)*

☐ Currently use tobacco/nicotine products: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco

☐ Other Amount / day: _____ Years: _____

☐ Former smoker: Amount / day: _____ Years: _____ Quit Date: _____

☐ Never smoked

☐ Consume alcohol: Y / N Type: _____

Amount / day: _____

☐ Use recreational drugs: Y / N Type: _____

Frequency: _____

☐ Exercise regularly: Y / N Type: _____

Frequency: _____

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? _____

Do you have a caregiver? Y / N If Yes, whom: _____

Do you have a good support network of family/friends? Y / N If No, please explain:

_____

Do you have any communication needs due to hearing, seeing or other issues such as memory or difficulty understanding or reading? Y / N If Yes, please explain: _____

Do you have any cultural needs or beliefs that affect your health care needs? If Yes, please explain:

_____

Do you have a health care proxy? Y / N / Not Sure

Do you have an advanced care directives? Y / N / Not Sure

Would you like to discuss planning Advance Directives at your visit? Y / N

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____

UB|MD INTERNAL MEDICINE

PRIMARY CARE ONLY

PATIENT NAME	BIRTH DATE / /

IMMUNIZATIONS & PREVENTIVE SERVICES *Check all that apply and PROVIDE DATE received*

PLEASE NOTE: All patients under 18 must have vaccine records either attached or transferred by previous MD

	DATE/Yr.		DATE/Yr.		DATE/Yr.
☐ **NONE**		☐ Last bloodwork	_____	☐ PAP smear	_____
☐ Flu vaccine	_____	Where:	_____	☐ Mammogram	_____
☐ MMR	_____	☐ HIV Testing	_____	Where:	_____
☐ Tetanus	_____	☐ Hepatitis C Testing	_____	☐ Bone density test	_____
☐ Prevnar vaccine	_____	☐ STD Testing	_____	☐ Colonoscopy	_____
☐ Pneumovax 23 vaccine	_____	☐ Hearing test	_____	Where:	_____
☐ Hepatitis B vaccines	_____	☐ Eye exam	_____	Who:	_____
☐ HPV vaccine	_____	☐ Dental exam	_____	☐ Abdominal Aortic Aneurysm Screening	
☐ Hepatitis A vaccines	_____	☐ OTHER	_____	Date/Yr:	_____
☐ Zoster Vaccine	_____	☐ OTHER	_____	Where:	_____

PERSONAL HABITS *Please complete the following information about yourself.*

Do you wear a seatbelt? Always / Occasionally / Never

Do you talk/text on phone while driving? Y / N

Do you have a smoke detector? Y / N

Do you have a carbon monoxide detector? Y / N

Do you have any unsecured guns in the home? Y / N

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

GOAL SETTING *Please complete the following information about yourself.*

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren.) _____

How do you plan to accomplish these goals? _____

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractors, genetics)

_____

_____

PHQ-2 *Please complete the following information about yourself.*

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1) Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

2) Feeling down, depressed, or hopeless: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____

UB|MD INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

REVIEW OF SYSTEMS

PATIENT NAME	BIRTH DATE / /	TODAY'S DATE / /

GENERAL HEALTH					
Is your general health good? ☐ Yes ☐ No					
Do you have or have you <u>recently</u> had:					
Gain or loss of weight without trying?	☐ Yes	☐ No	Drenching sweats at night?	☐ Yes	☐ No
Fever or chills?	☐ Yes	☐ No	Low energy	☐ Yes	☐ No
Changes in vision?	☐ Yes	☐ No	Contact or glasses	☐ Yes	☐ No
Itchy or dry eyes?	☐ Yes	☐ No			
Difficulty hearing?	☐ Yes	☐ No	Ringing in your ears?	☐ Yes	☐ No
Runny nose?	☐ Yes	☐ No	Congestion in your nose or sinus pain/pressure?	☐ Yes	☐ No
Change in your voice or hoarseness?	☐ Yes	☐ No	Dentures?	☐ Yes	☐ No
Chest pain?	☐ Yes	☐ No	Fainted or felt as though you were about to faint?	☐ Yes	☐ No
Feeling your heart skipping beats or racing?	☐ Yes	☐ No	Difficulty exercising due to shortness of breath/fatigue?	☐ Yes	☐ No
Pain in your buttocks (rear-end) or legs when walking?	☐ Yes	☐ No	Shortness of breath that awakens you at night?	☐ Yes	☐ No
Swollen legs or ankles?	☐ Yes	☐ No	Shortness of breath lying flat in bed?	☐ Yes	☐ No
Wheezing (high pitched breathing noises)?	☐ Yes	☐ No	Trouble staying awake in the daytime?	☐ Yes	☐ No
Cough?	☐ Yes	☐ No	Shortness of breath?	☐ Yes	☐ No
Decreased appetite?	☐ Yes	☐ No	Frequent diarrhea?	☐ Yes	☐ No
Difficulty swallowing?	☐ Yes	☐ No	Frequent constipation (hard, painful bowel movement/poop)?	☐ Yes	☐ No
Pain in your abdomen (belly)?	☐ Yes	☐ No	Black, tarry, or bloody stools (poops)?	☐ Yes	☐ No
Frequent indigestion/heartburn?	☐ Yes	☐ No	Change in color or size of stool?	☐ Yes	☐ No
Frequent nausea or vomiting?	☐ Yes	☐ No	Leaking of stool?	☐ Yes	☐ No
Burning when you urinate (pee)?	☐ Yes	☐ No	Weakness of urinary stream?	☐ Yes	☐ No
Leaking of urine?	☐ Yes	☐ No	Waking up more than twice per night to urinate?	☐ Yes	☐ No
Frequent urination?	☐ Yes	☐ No	Urgent need to urinate immediately?	☐ Yes	☐ No
Blood in your urine?	☐ Yes	☐ No			
WOMEN ONLY					
Irregular, heavy, or overly painful menstrual periods?	☐ Yes	☐ No	If you are postmenopausal (completed "change in life"), any vaginal bleeding since menopause?	☐ Yes	☐ No
Pain with sex?	☐ Yes	☐ No			
MEN ONLY					
Do you have difficulty achieving or maintaining an erection?	☐ Yes	☐ No			

PATIENT NAME	BIRTH DATE / /

Do you have or have you <u>recently</u> had:					
Unexplained muscle aches?	☐ Yes	☐ No	Joint stiffness upon awakening or sitting for prolonged period of time?	☐ Yes	☐ No
Joint aches?	☐ Yes	☐ No	Frequent back pain?	☐ Yes	☐ No
Swelling of your joints?	☐ Yes	☐ No	Fall(s)?	☐ Yes	☐ No
Skin rash?	☐ Yes	☐ No	Wound or sore on skin?	☐ Yes	☐ No
Dry skin?	☐ Yes	☐ No	Pain or lumps in your breasts?	☐ Yes	☐ No
New or changing mole(s)?	☐ Yes	☐ No	Nipple discharge?	☐ Yes	☐ No
Itching?	☐ Yes	☐ No			
Swollen glands?	☐ Yes	☐ No	Bruising without any explanation?	☐ Yes	☐ No
Bleeding from your gums or frequent nose bleeds?	☐ Yes	☐ No			
Frequent headaches?	☐ Yes	☐ No	Feeling that you are spinning or the room is spinning?	☐ Yes	☐ No
Loss of memory or feel confused frequently?	☐ Yes	☐ No	Loss of balance?	☐ Yes	☐ No
Numbness or tingling?	☐ Yes	☐ No	Tremor (shaking in your head/hand/foot)?	☐ Yes	☐ No
Feelings of being down, depressed, or hopeless?	☐ Yes	☐ No	Feelings of being overwhelmed by stress in your life?	☐ Yes	☐ No
Trouble falling or staying asleep, or sleeping too much?	☐ Yes	☐ No	Feelings of nervousness, anxiety, being on edge, or worried a lot about different things?	☐ Yes	☐ No
Thoughts that you would be better off dead or of hurting yourself in some way?	☐ Yes	☐ No			
Sensitivity to heat or cold, more than most people?	☐ Yes	☐ No	**WOMEN ONLY:**		
Excessive thirst?	☐ Yes	☐ No	Do you have excessive hair on the face, chest, or abdomen?	☐ Yes	☐ No
Decreased interest in sex?	☐ Yes	☐ No			

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____

HEALTHeLINK

Patient Consent to Participate in HEALTHeLINK Health Information Exchange
Level 1 Multi-Provider/Multi-Payer Consent

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

SELECT ONLY ONE

☐ **YES** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL of** my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."

☐ **YES EXCEPT** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL** of my electronic health information through HEALTHeLINK except the following Participants:

Participant's Name **Participant's address or phone number**

These Participants cannot access my electronic health information via HEALTHeLINK *EXCEPT in a medical emergency*. If you have chosen to exclude any Participants, you **must** contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here ☐

☐ **NO EXCEPT** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, EXCEPT *in a medical emergency*. By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."

☐ **NO NEVER** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, INCLUDING *in a medical emergency*.

NOTE: Unless you select "NO NEVER" New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE

Patient Last Name:

Patient First Name:

/ / ☐ **Male** ☐ **Female**

Patient Date of Birth:

Patient Address

City **State** **ZIP**

Signature of Patient or Patient's Legal Representative **Date of Signature**

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ parent ☐ healthcare agent/proxy ☐ guardian ☐ other _____

Entity Consent Received By

WITNESS *

* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.

Print Name of Witness

Signature of Witness

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

UB|MD INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

HIPAA Contact and Authorization for Release

1001 Main Street
Buffalo, NY 14203
P: (716) 961-9900
F: (716) 961-9911

1020 Youngs Rd.
Williamsville, NY 14221
P: (716) 961-9900
F: (716) 961-9911

6105 Transit Rd.
E. Amherst, NY 14051
P: (716) 348-3435
F: (716) 204-8229

300 Linwood Ave.
Buffalo, NY 14209
P: (716) 961-9400
F: (716) 961-9402

6400 Edgewood Dr.
Niagara Falls, NY 14304
P: (716) 898-4803
F: (716) 898-3928

462 Grider St.
Buffalo, NY 14215
Nephrology
P: (716) 898-4803
F: (716) 898-3928
Behavioral Med:
P: (716) 898-5671

Patient Name:	**Date of Birth:** / /

Receipt of Notice of Privacy Practices

I have received a copy of the UBMD Internal Medicine, Inc. Notice of Privacy Practice. (also available at UBMDIM.COM)

Signature:	Date: / /

☐ Patient refused and/or unable to sign
Staff member signature:

Authorization to Release Information to Family and/or Friends

Name	Relationship	Primary Phone	Secondary Phone

Authorization to Leave Messages

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you:

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
Voice Mail on Alternate Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
		May we send a message?	
Send through US Mail		☐ Yes ☐ No	

Restrictions to Release of Information

Please list any restrictions regarding information to be released:

Signature

Signature:	Date: / /

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

PLEASE SEND TO PREVIOUS PRACTICE

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Please complete

Name and address of doctor (or other health professional) to release this information (e.g., your previous primary doctor)

8. Name and address of person(s) or category of person to whom this information will be sent: **UBMD INTERNAL MEDICINE**

Please complete

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Only if to Atty/Gov

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

Please complete

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:

Only if not patient

12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Please Sign/Date

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

UB|MD
INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

1020 Youngs Rd.
Williamsville, NY 14221
P: 716.961.9900
F: 716.961.9911

1001 Main Street
Buffalo, NY 14203
P: 716.961.9900
F: 716.961.9911

6105 Transit Rd.
E. Amherst, NY 14051
P: 716.348.3435
F: 716.204.8229

300 Linwood Ave.
Buffalo, NY 14209
P: 716.961.9400
F: 716.961.9402

6400 Edgewood Dr.
Niagara Falls, NY 14304
P: 716.898.4803
F: 716.898.3928

462 Grider St.
Buffalo, NY 14215
Nephrology
P: 716.898.4803
F: 716.898.3928
Behavioral Med:
P: 716.898.5671

UBMD Internal Medicine Patient Agreement

Thank you for choosing UBMD Internal Medicine as your healthcare provider. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, below is some introductory information and our financial policy.

General Information
Billing Office: 716.816.7200
Hours: Monday - Friday 7:30 am – 4:30 pm
Patient Website: ubmdim.com

If you wish to contact a physician regarding a medical matter, please call the appropriate office above or use the Patient Portal (see information on page 2). **DO NOT contact physicians via University or buffalo.edu email**, as they are not HIPAA-compliant and do not offer protection for health information. A medical provider is on call seven (7) days a week to take urgent calls outside normal business hours. Your call will be returned within one (1) hour. **For emergencies, call 911.**

Our phone message is updated as needed to report any weather-related closings.

Appointments
Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur) and aim for patients to be in the exam room at their appointment time. You will receive an automated pre-appointment reminder call two (2) to five (5) business days before your appointment. It is important for you to notify our office if your phone number has changed. Please specify if you prefer your home or mobile number as your primary contact.

Prescription Refills.
For routine refills, please contact your pharmacy and have them send a prescription refill request electronically. Refills can be requested through our Patient Portal for those who are currently enrolled. Please allow five (5) business days to have all medications refilled. For refill requests needed in less than five (5) business days, contact the office.

Form Completion Fee
There will be a $10 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of request. Please allow seven (7) business days for us to complete any forms.

Test Results
Please allow seven (7) business days for laboratory results or other diagnostic test results unless instructed by your physician. Your physician will review all test results and contact you if follow up is needed. Routine lab results may be relayed by postal mail, patient portal or telephone.

Address and/or Phone Number Change
Please advise our practice anytime there is a change in your address, phone number, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

Financial Policy
Your clear understanding of our Patient Financial Policy (available on our Patient Resources web page, or by request at the office) is important to us. Please ask if you have any questions about our fees, policies, or your responsibilities.

Insurance Verification and Copayments
Patients are expected to present valid photo identification and their insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing supervisor. Failure to pay your copay at the time of service will result in an additional $10 fee. We accept cash, check, credit card or flexible spending card. No post-dated checks are accepted. A $35 returned check fee is added to any insufficient funds amount owed by the patient. The patient may be placed on a cash-only basis following any returned check.

Insurance Claims
The practice will bill the patient's primary insurance company. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance, as well as any insurance changes. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although the practice may estimate the amount the insurance company may pay, it is the insurance company that makes the final determination of the patient's eligibility and/or benefits. The patient is responsible and agrees to pay for any non-covered services provided. If the insurance company is not contracted with the practice, the patient agrees to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

Participating Insurances
The practice accepts most insurance plans including but not limited to: Blue Cross/Blue Shield, Empire, Fidelis, Independent Health, Univera, United Healthcare, Wellcare, and Medicare. Participation in insurance plans may change. It is your responsibility to verify if UBMD Internal Medicine participates in your plan. If your physician does not participate with your insurance, you have the right to request an estimate of cost.

High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)
If your insurance is a High Deductible Plan, you will be required to pay a $75 deposit prior to your visit. If the total cost of services rendered is more than $75 you will be billed for the remaining amount. If the cost of your visit is less than $75 we will send you a refund for the difference. Refunds will be issued within 60 days if the overall patient account has a credit balance.

Referrals and Authorizations
It is the patient's or guarantor's responsibility to be aware of the details of his/her insurance coverage, including any requirements for referrals and/or authorizations. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage. If your insurance company requires a referral and/or authorization (for specialist visits/testing), you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment or no payment from the insurance company and the balance will be the patient's responsibility. To verify if we have received the appropriate referral or authorization, please contact our office.

Patient Portal
The UBMD FollowMyHealth Patient Portal provides all participating UBMD patients the ability to communicate securely and manage their own healthcare with UBMD providers, 24 hours, seven (7) days a week. All messages received through the Patient Portal will be answered within one (1) business day. The ability to view portions of your medical records, verify or request appointments, request prescriptions, update demographic information, receive reminders and ask a question of your provider are some functions of the portal. All patients are encouraged to notify our UBMD Internal Medicine staff by phone/at your next visit to request an invitation to create an account on FollowMyHealth to become participants of the UBMD Patient Portal.

Self-pay Accounts
Self-pay accounts are for patients without insurance coverage or patients without an insurance card on file with UBMD. This includes patients who have applied for Medicaid but who do not yet have a valid Medicaid number. The practice does not accept attorney letters or contingency payments. It is always the patient's responsibility to know if the practice participates with their insurance plan. If there is a discrepancy with the insurance information on file with the practice, the patient is considered self-pay unless otherwise proven. Self-pay patients are expected to make a down payment at the time of service *($115 for new patients* and *$75 for established patients*). If the down payment does not cover all treatment charges, the patient is billed for the remaining balance. Payment plans are available if needed. Please contact the billing office (716.816.7200) to discuss a mutually agreeable payment plan. It is not the intention of the practice to cause hardship to patients, only to provide them with the best care possible and the least amount of stress. Failure to make the deposit at the time of service, will result in an additional $10 fee.

Workers' Compensation and Automobile Accidents (No Fault)
In the case of a workers' compensation injury or automobile accident, the patient must have the claim number, phone number, contact person, and name and address of the insurance carrier with them at the office visit. If this information is not provided, the patient will be asked to either reschedule the appointment or pay for the visit at the time of service.

No Show/Cancellation Fee
The practice requires 24-hour notice of appointment cancellation. If this procedure is not followed, a $35 fee is assessed to the patient.

Medical Record Copies
Patients requesting copies of medical records are charged $.75 per page. A charge of $15 applies for the retrieval of records in off-site storage, including those medical records transferred from another practice.

Minors
The parent or guardian who holds the insurance for the child is considered the guarantor for the child and is responsible for full payment regardless of personal circumstances. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
A billing statement is sent to the patient/guarantor upon rendering of services. Statements are mailed every twenty-eight (28) days thereafter. If a patient's account is sixty (60) days past due, the patient is sent a Final Collection letter requesting payment within fifteen (15) days. Telephone calls may be made to the patient prior to sending an account to a collection agency in a final attempt to collect the outstanding balance. If no payment is received, the account is sent to a collection agency. Statements returned with an invalid address, will be sent to the collection agency. Any account sent to a collection agency will include collection, attorney and court fees and may be reported to credit bureaus.

Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made, pursuant to this agreement, your account may be turned over to a collection agency.

Regardless of any personal arrangements that a patient might have with outside individuals or groups, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other individual.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

UBMD Internal Medicine

Assignment of Benefits, Financial Responsibility, Release of Information And Receipt of Notice of Privacy Practices

- **Assignment of Benefits**
  I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to UBMD Internal Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
  Please initial x_____

- **Financial Responsibility**
  I have requested medical services from UBMD Internal Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I also acknowledge that I have read the financial policy of the practice, agree to be bound by its terms and understand that such terms may be amended from time-to-time by the practice.
  Please initial x_____

- **Release of Information**
  I authorize the release of necessary medical information to UBMD Internal Medicine for the purpose of processing this or any related claim. I also authorize UBMD Internal Medicine to release requested documentation of this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition.
  Please initial x_____

- **Teaching Facility**
  I acknowledge that UBMD Internal Medicine is affiliated with the University at Buffalo School of Medicine and Biomedical Sciences and as such students may become involved in my care. If you are concerned about the involvement of medical students, please speak to the physician responsible for your care.
  Please initial x_____

- **Phone Notifications**
  I authorize UBMD Internal Medicine to remind me of my appointments and other useful information using automatic, prerecorded or artificial voice calls to me on the phone number I listed; even if it is a cellular phone number
  Please initial x_____

- **Notice of Privacy Practices**
  We are required to provide you a copy of our Notice of Privacy Practices which describes how medical information about you may be used and disclosed and how you can get access to this information. Any restrictions concerning the use of your personal medical information must be made in writing. By signing below, I acknowledge that I received a copy of UBMD Internal Medicine's Notice of Privacy Practices.
  Please initial x_____

Documentation of Good Faith Efforts – For UBMD Internal Medicine use only

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of UBMD Internal Medicine's Notice of Privacy Practices. However, such acknowledgment was not obtained because:

_____ Patient refused to sign
_____ Due to an emergency, it was not possible to obtain an acknowledgement
_____ Unable to communicate with patient
_____ Other (please provide specific details)

_____

_____

_____ _____

Employee Signature Date

_____ _____

Patient Name (print) Patient Date of Birth

_____ _____

Patient Signature or Responsible Party if a Minor Date