



Ninth Avenue Internal Medicine, LLC



ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____
Last First MI Home Phone

Cell Phone _____

Home Address: _____ Mailing Address: _____
Street Street

City State Zip City State Zip

DOB: _____ Age: _____ ☐ M ☐ F SS# _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other
Sex Marital Status

E-mail _____ Emergency Contact _____

Responsible Party: _____
Name Relationship Contact Phone

Race: _____ Ethnicity: _____ Language: _____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about us? _____

Primary Ins: _____ Phone: _____

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Phone: _____

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to NAIM, LLC. I also authorize agents of any hospital, treatment center or previous physicians to furnish NAIM, LLC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within NAIM, LLC.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to NAIM, LLC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to NAIM, LLC.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with NAIM, LLC.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Patient Signature _____ Date _____

Responsible Party Signature _____ Relationship _____ Date _____

Employee Initials _____

For Office Use Only

CONFIDENTIAL

Copies to – Medical Record and Patient



Ninth Avenue Internal Medicine, LLC



Ninth Avenue Internal Medicine, LLC
4500 East Ninth Avenue, Suite 140 Denver, CO 80220
Phone (303) 394-2152 Fax (303) 394-2496

HISTORY AND PHYSICAL FORM, NEW PATIENT

Welcome to our practice. Please fill in the blanks with your information. The information below will help our doctors. Thank you.

Name _____ Date _____
Last, First
Date of birth _____ Social security number: _____

Chief Complaint: _____

Is your visit today result of the injury or motor vehicle accident? ☐ Yes ☐ No

Are you having a surgery soon and this is a preoperative visit? ☐ Yes ☐ No

If yes, please specify _____

Past Medical History:

Head, Eyes, Ears, Nose & Throat

- ☐ Cataract
- ☐ Glaucoma
- ☐ Poor vision
- ☐ Ear infections (frequent)
- ☐ Ringing
- ☐ Hearing problems
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat (frequent)
- ☐ Other (specify) _____

Respiratory System:

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Pulmonary hypertension
- ☐ Other (specify) _____

Cardiovascular System

- ☐ Heart attack _____
- ☐ Coronary artery disease
- ☐ Irregular heartbeat
- ☐ Heart murmurs
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ ICD or ☐ Pacemaker
- ☐ Peripheral vascular disease
- ☐ Syncope
- ☐ Stress test or angiogram _____
- ☐ Other (specify) _____

Genitourinary Systems

- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Urinary incontinence
- ☐ Renal insufficiency/failure
- ☐ Hemodialysis
- ☐ Frequent urinary infections
- ☐ Urethral/Vaginal discharge
- ☐ Venereal disease (STD)
- ☐ Sexual/Erectile dysfunction
- ☐ Menstrual dysfunction/ infertility
- ☐ Other (specify) _____

Tumors/ Blood disorders

- ☐ Blood clots
- ☐ Bleeding/ Easy bruising
- ☐ Anemia
- ☐ Leukemia/lymphoma
- ☐ Lung cancer
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Colon cancer
- ☐ Skin cancer
- ☐ Other (specify) _____

Neurological:

- ☐ Migraine headaches
- ☐ Seizures
- ☐ Stroke
- ☐ Chronic tremor /Parkinson's
- ☐ Other (specify) _____

Digestive System:

- ☐ Peptic ulcer
- ☐ Gastroesophageal reflux/ Heartburn
- ☐ Hiatal hernia
- ☐ Difficulty swallowing
- ☐ Loss of appetite/ Nausea/ Vomiting
- ☐ Hepatitis/ Jaundice
- ☐ Gall bladder problems
- ☐ Pancreatitis
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Bleeding (GI tract)
- ☐ Diverticulosis ☐ Diverticulitis
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Lactose intolerance
- ☐ Polyps
- ☐ Hemorrhoids
- Last colonoscopy: _____
- ☐ Normal ☐ Abnormal
- ☐ Other (specify) _____

Female only:

- Pregnant ☐ Yes ☐ No
- Periods ☐ Regular ☐ Irregular ☐ Painful
- Days of flow___ Length of Cycle___
- Pregnancies___ Abortions___
- Miscarriages___ Live Births___
- Birth control method _____
- Last PAP test ____/____/____
- ☐ Normal ☐ Abnormal
- ☐ Menopause
- Last mammogram _____
- ☐ Breast lump ☐ Normal ☐ Abnormal

Muscular:

- ☐ Muscular weakness
- ☐ Numbness/ Tingling
- ☐ Chronic back pain
- ☐ Chronic neck pain
- ☐ Arthritis/Joint pain
- ☐ Gout
- ☐ Osteoporosis
- ☐ Broken bones (list) _____
- ☐ Other (specify) _____

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Steroids dependent conditions
- ☐ Early menopause
- ☐ Osteoporosis
- ☐ Other (specify) _____

Vascular

- ☐ Varicose veins
- ☐ Claudication (leg pain with walking)
- ☐ Deep venous thrombosis
- ☐ Carotid stenosis
- ☐ Other (specify) _____

Mental:

- ☐ Anxiety
- ☐ Memory loss
- ☐ Insomnia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Depression
- ☐ Bipolar disorder
- ☐ ADHD
- ☐ Other (specify) _____

Surgical and Hospitalization History:

Diagnosis or Procedure	Date performed	Hospital	Physician (Surgeon)	Details

Pharmacy used:

Pharmacy: _____
 Address: _____

Oxygen/Medical equipment companies used:

Name, Phone number: _____

Medications used:

Medication (name)	Dose	Frequency

Medication allergies:

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

Food allergies: _____

Family History (indicate relationship) <input type="checkbox"/> Heart attack/ Coronary artery disease _____ <input type="checkbox"/> Alzheimer's disease _____ <input type="checkbox"/> Familial hyperlipidemia _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Cancer (specify) _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Thyroid disease _____ <input type="checkbox"/> Blood clots _____ <input type="checkbox"/> Psychiatric/mental conditions _____ <input type="checkbox"/> Seizure disorder _____ <input type="checkbox"/> Other (specify) _____	Social history: <div style="display: flex; justify-content: space-between;"> <div> Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed </div> <div> Occupation: _____ </div> </div> Alcohol: <input type="checkbox"/> Yes _____ drinks per day/week/month <input type="checkbox"/> No _____ <input type="checkbox"/> Quit in _____ <input type="checkbox"/> Tobacco/ <input type="checkbox"/> Marijuana use: <input type="checkbox"/> Yes _____cigs/day _____years <input type="checkbox"/> No _____ <input type="checkbox"/> Quit in _____
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Vaccinations received:

- ☐ Tetanus, Td or Tdap _____
☐ Influenza _____
☐ MMR _____
☐ Hepatitis B _____
☐ Hepatitis A _____
☐ Varicella _____
☐ COVID19 _____
☐ Gardasil _____
☐ Meningitis _____
☐ Pneumovax _____
☐ Shingrix _____
☐ RSV _____

☐ Other (specify) _____



Ninth Avenue Internal Medicine, LLC



Authorization for Release of Medical Records

I, _____, authorize Ninth Avenue Internal Medicine, LLC to receive a copy of my Medical Records, including the following items:

The purpose of this disclosure is for: _____

Information may be released from the following physician offices:

Please send copies to:

Ninth Avenue Internal Medicine, LLC
4500 E. 9th Avenue, Suite 140
Denver, CO 80220
Phone: 303-394-2152
Fax: 303-394-2496

1. I understand this authorization will expire, without my express revocation, one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
2. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.
3. I understand that any information disclosure has the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
4. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy or facsimile of this consent is as valid as the original. I understand that I might be denied service if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. At my request a copy of this form will be provided to me.

Patient Signature

Date

Date of Birth

Social Security Number



Ninth Avenue Internal Medicine, LLC



Patient Name _____

CONTACT LIST

Contact Name: _____
Last First Telephone

Address: _____

City State Zip

☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Emergency ☐ Other

Contact Name: _____
Last First Telephone

Address: _____

City State Zip

☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Emergency ☐ Other

1. I hereby authorize Ninth Avenue Internal Medicine, LLC to use and disclose my personal health information to the individuals identified on this form.
2. I understand that the individuals identified on this form will be treated by Ninth Avenue Internal Medicine, LLC as individuals involved directly in my care and as such Ninth Avenue Internal Medicine, LLC will be allowed to release my personal health information to these individuals for the purpose of treatment, payment and healthcare operations.
3. I understand that I have a right to request and receive a Notice of Privacy from Ninth Avenue Internal Medicine, LLC.

THIS AGREEMENT CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statement and accepted the terms. A duplicate of the statement is considered the same as the original.

I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ninth Avenue Internal Medicine, LLC will not be affected if I refuse to sign this authorization.

Patient or Personal Representative Signature

Date/Time



Ninth Avenue Internal Medicine, LLC



Drs. Igor Borisov, MD and Daniel Witten, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ninth Avenue Internal Medicine, LLC is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

_____(INITIAL HERE) I acknowledge that I have received a copy of the This Notice of Privacy Practices of Ninth Avenue Internal Medicine, LLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF COLORADO MEDICAL ARBITRATION PROGRAM

_____(INITIAL HERE) I acknowledge that I have read the Colorado Medical Arbitration Program Agreement and agree that any claim I may have in the future against the doctor and Ninth Avenue Internal Medicine; LLC or any derivative claim arising out of the same incident will be resolved by arbitration rather than in court trial by judge and jury.

Patient or Personal Representative Name (Print): _____

Patient or Personal Representative Signature: _____

Date: _____

For Office Use Only:

Reason acknowledgement was not obtained:

EMPLOYEE INITIAL



Ninth Avenue Internal Medicine, LLC



OUR FINANCIAL POLICY

Welcome to Ninth Avenue Internal Medicine, LLC. We are committed to your healthcare needs. We recognize the need for our patients to have a better understanding regarding payment for medical services and insurance. Please read and familiarize yourself with the information. We require you to read and sign it prior to any treatment.

INSURANCE

We will gladly bill your insurance carrier on your behalf if you have provided us with all the necessary information to do so. Please remember that your health insurance policy is a contract between you and your Insurance Company, not between the Provider and your insurance company. We will do our best to verify eligibility and benefits; however it is ultimately your responsibility to see that your bill is paid in full.

Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. Any questions or complaints regarding your coverage should be directed to your insurance carrier. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. All co-pays and deductibles are due prior to treatment.

Many insurance companies require a Primary Care provider (PCP) to be listed on the plan. You will need to ensure that our physician is listed as your PCP prior to your scheduled appointment. If your plan lists another physician as the PCP on your plan we will be unable to accept your insurance card. There are no "free" visits. Any time you are seen by one of our providers there will be a charge for their services. There are limited exceptions to this rule such as additional immunizations in a series. Your insurance company should provide an Explanation of Benefits (EOB) which shows the amount you are responsible for. Your insurance benefits determine this amount. We only bill you for what your insurance benefits do not cover.

SELF-PAY

If you do not have insurance we offer self-pay patient rates. New patient's consultations are \$249, consultations for existing patients are \$115. This fee covers the consultation only, any procedures or labs are at additional cost.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with Rita in the billing office at 303-394-2152 ext. 5. If we bill your insurance and reimbursement is 100% denied we will bill you our Self Pay charges. If you are unsure of self-pay rates, it is your responsibility to ask. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service. We will send you several invoices for any outstanding balances after which we will charge the Credit Card on file and mail you a receipt. Should the Credit Card decline and no payment has been made within 90 days your account will be turned over to a collection agency and you will not be able to schedule appointments, request or receive refills and you may be permanently dismissed from our practice. If you do not have sufficient funds to cover a transaction, you will be charged \$25 per item.

We have designated fees per form payable in cash or credit card due when the form is picked up. These fees vary based on the complexity of the forms. Forms may include: Disability, School and Work Physicals, Public Service Requests, FLMA and other miscellaneous forms.

NO SHOW & LATE CANCELLATION

If you are unable to make your appointment, YOU MUST NOTIFY THE CLINIC AT LEAST **24 HOURS** IN ADVANCE AND RESCHEDULE YOUR APPOINTMENT. If you have not notified our office 24 hours in advance you may be charged a fee up to **\$150.00**. You will be considered for termination from the practice once you have multiple no-show appointments.

I have read the *Financial Policy*; I understand and agree to this *Financial Policy*.

Print Name: _____

Patient Signature: _____ Date: _____

Credit Card on record in order to cover any portion of my deductible/ co insurance or co-pay, or any outstanding balances that will be determined by my insurance company. I agree for this card to be charged in accordance with my Credit Card Agreement and understand that a receipt for said charges will be mailed to the address on file with this office. I will notify the office on any changes to this Credit Card.

Visa ____ Master Card ____ AmEx ____ Discover ____ Care Credit ____

Card # _____ Exp Date: _____ Code _____

Patient Name _____ Patient Signature: _____ Date : _____

Estimates of your Benefits (New Patients Only) : There is a \$ _____ yearly deductible and/or \$ _____ co-insurance/co-pay on my health insurance policy.