Welcome to our Practice

We look forward to meeting you!

In order to provide you with the best care, please complete the following check list for your visit.

New Patients

Please bring:

1. Insurance card(s), if you have a second insurance please bring both cards.
2. Driver's license or other photo ID.
3. Current medications and dosages (including vitamins and supplements).
4. Prior medical records, including immunization records.
5. Co-pay required by your insurance plan.
6. Print and fill-out the new patient information forms on our website.

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

NEW PATIENT REGISTRATION

Welcome to our practice. Please print all information.

Is this visit related to Worker's Compensation Yes___ No___ Motor Vehicle Accident/Personal Injury? Yes___ No___

PATIENT INFORMATION:

Name:_____ DOB:_____ Male___ Female___
Mailing Address:_____ City:_____ State:_____ Zip:_____
Street Address and Town *(if different from above)*: _____
Phone Numbers: Home:_____ Work:_____ Cell:_____
Social Security#:_____ Email Address:_____
Marital Status: Single___ Married___ Divorced___ Widowed___ Partner___ Legally Separated___
Employer:_____ Full time:__ Part time:__ Not Employed: __Student: __

IF PATIENT IS A CHILD: *(under 18 years of age)*

Father's Name:_____ DOB:_____
Mother's Name:_____ DOB:_____

PRIMARY INSURANCE:

Name:_____
Policy Number:_____
Group Number:_____
Insured's Name:_____DOB:_____
Insured's SS#_____
Relationship to Insured:_____

SECONDARY INSURANCE:

Name:_____
Policy Number:_____
Group Number:_____
Insured's Name:_____DOB:_____
Insured's SS#_____
Relationship to Insured:_____

RESPONSIBLE PARTY *(if different from the patient) person responsible for bills, not necessarily the insurance subscriber:*

Name:_____ DOB:_____ Relationship to Patient:_____
Mailing Address:_____City:_____ State:_____ Zip:_____
Phone Numbers: Home:_____ Work:_____ Cell:_____
Email Address:_____

EMERGENCY CONTACT:

Name:_____ Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip_____
Phone Numbers: Home:_____ Work:_____ Cell:_____

Race: _____ Ethnicity: _____ Language: _____

Disclosure of Protected Health Information of a Minor *(only applicable for minor patient's age 11 through 18th birthday)*

I understand that medical records containing the following information about the care listed below:

- HIV testing and treatment
- Testing and treatment for reportable sexually transmitted diseases
- Family Planning and abortion services
- Alcohol and drug treatment services

by law, cannot be disclosed by **Paul H. Deutsch M.D., R.Ph., LLC** to the parent/guardian of a minor patient unless permission is granted by the minor. On some occasions, AMA may call the minor about the release of his/her information.
Minor's cell phone or contact number:_____

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

RECEIPT OF PRIVACY NOTICE, ASSIGNMENT OF BENEFITS, RX HISTORY CONSENT

Name of Patient: _____ DOB: _____

Please complete all sections below. This must be completed prior to your visit. The signature of the patient, the custodial parent, or the legally responsible party is required.

Privacy Practices (HIPAA)

By signing below I acknowledge that I was provided with the Notice of Privacy Practices from the office of **Dr. Paul H. Deutsch M.D., R.Ph., LLC., Nicole Fur Furo, Practice Administrator, Privacy Officer.**

Signature:_____Date:_____

Permission to Leave Messages

By signing below, I authorize **Paul H. Deutsch M.D., R.Ph., LLC** to leave messages in reference to any items that assist in carrying out my healthcare.

Home Phone: Yes__ No__ **Work Phone:** Yes__ No__ **Cell Phone**: Yes__ No__
Preferred Phone: **Home**__ **Cell**__ **Work**__
Preferred Time of Day for Messages: **Morning**__ **Afternoon**__ **Evening**__

Name of person(s) Dr. Deutsch may discuss my healthcare with:
Name:_____ Relationship to patient:_____ Phone #_____
Name:_____ Relationship to patient:_____ Phone #_____

Signature:_____Date:_____

Payment, Assignment, and Release

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to **Paul H. Deutsch M.D., R.Ph., LLC.**
I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

Signature:_____Date:_____

RX History Consent

By signing below, I agree to allow **Paul H. Deutsch M.D., R.Ph., LLC** to review any prescription history available to my electronic health record.

Signature:_____Date:_____

Pharmacy Information:

Local Pharmacy Name:_____Location:_____
Mail Order Pharmacy Name:_____Fax#:_____

PAUL H DEUTSCH MD, RPH LLC
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

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 inhalers

Name the Drug	Strength	Frequency Taken

Medical History

Allergies to medications

Name the Drug	Reaction You Had

Patient Name:		DOB:
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT HEALTH PROBLEMS	
Father			☐ Alive ☐ Deceased	**Children**			☐ Alive ☐ Deceased
Mother			☐ Alive ☐ Deceased				☐ Alive ☐ Deceased
Sibling	☐ M ☐ F		☐ Alive ☐ Deceased	☐ M ☐ F			☐ Alive ☐ Deceased
	☐ M ☐ F		☐ Alive ☐ Deceased	☐ M ☐ F			☐ Alive ☐ Deceased
	☐ M ☐ F		☐ Alive ☐ Deceased	**Grandfather** *Paternal*			☐ Alive ☐ Deceased
	☐ M ☐ F		☐ Alive ☐ Deceased	**Grandmother** *Paternal*			☐ Alive ☐ Deceased
	☐ M ☐ F		☐ Alive ☐ Deceased	**Grandfather** *Maternal*			☐ Alive ☐ Deceased
	☐ M ☐ F		☐ Alive ☐ Deceased	**Grandmo**			☐ Alive ☐ Deceased

				Maternal other			

Please turn to next page

Patient Name: DOB:

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Tobacco	Do you use tobacco?				
	Cigarettes – pks./day	Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit			
Exercise	Sedentary (No exercise)				
	Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)				
Caffeine	None	Coffee	Tea	Cola	
	# Of cups/cans per day?				
Personal Safety	Do you live alone?			Yes	No
	Do you have frequent falls?			Yes	No
	Do you have vision or hearing loss?			Yes	No
	Do you have an Advance Directive or Living Will?			Yes	No
	Would you like information on the preparation of these?			Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			Yes	No
Drugs	Do you currently use recreational or street drugs?			Yes	No
	Have you ever given yourself street drugs with a needle?			Yes	No
Sex (if applicable)	Are you sexually active?			Yes	No
	If yes, are you trying for a pregnancy?			Yes	No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			Yes	No
	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?			Yes	No
Dieting	Are you dieting?			Yes	No
Alcohol	Do you drink alcohol?			Yes	No
	How many drinks per week?			Yes	No
	Are you concerned about the amount you drink?			Yes	No
	Have you considered stopping?			Yes	No
	Have you ever experienced blackouts?			Yes	No
	Are you prone to "binge" drinking?			Yes	No
	Do you drive after drinking?			Yes	No

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

Please Turn to Next Page

Patient Name: DOB:

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times _____		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?	Yes	No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	

Notice of Privacy Practices

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

The office of **Paul H. Deutsch M.D., R.Ph., LLC** is required by law to maintain the privacy of your health information and to provide you with the notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at the

office of **Paul H. Deutsch M.D., R.Ph., LLC** please contact: **Nicole Fur Furo, Privacy Officer, 86 New London Turnpike Norwich, CT 06360, phone: 860 889-0025**

Effective Date of This Notice: **October 1, 2013**

I. How the office of Paul H. Deutsch, M.D., R.Ph., LLC may Disclose Your Health Information

The office of **Paul H. Deutsch, M.D., R.Ph., LLC** collects health information from you and stores it in your electronic health record (EHR) on a computer. This is your medical record. The medical record is the property of the office of **Paul H. Deutsch, M.D., R.Ph., LLC**, but the information in the medical record belongs to you. The office of **Paul H. Deutsch, M.D., R.Ph., LLC** protects the privacy of your health information. The law permits the office of **Paul H. Deutsch, M.D., R.Ph., LLC** to disclose your health information for the following purposes:

1. **Treatment**. We may disclose PHI (protected health information), as needed, to other providers to whom we refer or in a medical emergency so that the treating practitioner has the information necessary to diagnose and treat you.

2. **Payment**. We may disclose PHI, as needed, to obtain payment from your health insurance plan (including Medicare) to determine eligibility or coverage for insurance benefits and to undertake medical necessity and utilization activities, e.g. obtaining approval for a hospital stay.

3. **Regular Health Care Operations**. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management.

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Sign in Sheet**. We may ask you to sign in when you arrive at our office. The sign in sheet will contain only minimal information. We may also call out your name when we are ready to see you.

6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts.

7. **Required by Law**. As required by law, we may use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

8. **Public Health**. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or other abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

9. **Health Oversight Activities**. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

10. **Judicial and administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

11. **Law Enforcement**. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

12. **Deceased Person Information**. We may disclose your health information to coroners, medical examiners and funeral directors.

13. **Organ Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. **Public Safety**. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. **Specialized Government Functions**. We may disclose your health information for military, national security, or prisoner (and government benefits) purposes.

16. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws.

17. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related in the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

18. **Change of Ownership**. In the event that the office of **Paul H. Deutsch, M.D., R.Ph., LLC** is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When the office of Paul H. Deutsch, M.D., R.Ph., LLC May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the office of **Paul H. Deutsch, M.D., R.Ph., LLC**, will not use or disclose your health information without your written authorization. If you do authorize the office of **Paul H. Deutsch, M.D., R.Ph., LLC** to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. A written request is required specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. We will accommodate all reasonable requests and we will not require an explanation from you as to the basis of your request.

3. You have the right to inspect and copy your health information with limited exceptions. We may charge a reasonable fee for copies. We may require inspection or copy requests to be in writing. We may deny your request under limited circumstances and you may have a right to appeal our decision. If your written request clearly, conspicuously and specifically asks us to send you or some other person or entity an electronic copy of your medical record, and we do not deny the request as discussed above, we will send a copy of the electronic health record as you requested, and will charge you no more than what it cost us to respond to your request.

4. Depending on the circumstances, you may have the right to amend PHI. In certain cases the office of **Dr. Paul H. Deutsch, M.D., R.Ph. LLC** may deny your request because we believe that the PHI is accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us which we will consider. We may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

5. You have a right to receive an accounting of disclosures of your health information made by the office of **Paul H. Deutsch, M.D., R.Ph., LLC** except that the office of **Paul H. Deutsch, M.D., R.Ph., LLC** does not have to account for the disclosures described in treatment, payment, health care operations, information provided to you, and certain government functions of section **I** of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices.

IV. Disclosure of PHI of a Minor

1. The office of **Paul H. Deutsch, M.D., R.Ph., LLC** by Connecticut State Law, cannot disclose to the parent/guardian of a minor patient any information about the care listed below, if and as applicable, unless permission is granted by said minor.

- HIV testing and treatment.
- Testing and treatment for reportable sexually transmitted diseases.
- Family planning and abortion services.
- Alcohol and drug treatment services.

V. Change to This Notice of Privacy Practices

The office of **Paul H. Deutsch, M.D., R.Ph., LLC** reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, the office of **Paul H. Deutsch, M.D., R.Ph., LLC** is required by law to comply with this Notice.

VI. Complaints

Complaints about this Notice of Privacy Practices or how the office of **Paul H. Deutsch, M.D., R.Ph., LLC** handles your health information should be directed to: **Nicole Fur Furo, Privacy Officer, phone: 860 889-0025.**

If you are not satisfied with the manner in which the office of **Paul H. Deutsch, M.D., R.Ph., LLC** handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html, or you may also submit your complaint electronically by visiting http://www.hhs.gov.ocr/privacy/index.html

You will not be penalized for filing a complaint.