ADVANCED CARDIOVASCULAR INTERVENTIONS, PA
6-20 Plaza Rd. Fairlawn, NJ 07410 20 Prospect Ave. Suite 809 Hackensack, NJ 07601
P:201-265-5700 *F:855-265-7385*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our Notice may change and be revised. If we change our Notice, you may obtain a copy by requesting one verbally or in writing.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received Notice of Privacy Practices.

_____ _____

Name of Patient D.O.B.

_____ _____

Patient's Signature Date

ADVANCED CARDIOVASCULAR INTERVENTIONS PA
Dr. Hamid M. Nia, F.A.C.C
20 Prospect Ave, Suite 600
Hackensack, NJ 07601
Phone: 201-265-5700 Fax: 855-265-7385

Assignment of Benefits Form(AETNA)

Patient:_____ **ID#:**_____

I, _____, understand that services rendered to me by (**ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA**) are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to (**ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA**) and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by **AETNA.**

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to (**ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA**) within 48 hours. I agree that if I fail to send the payment to (**ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA**) and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize (**ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA**) to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

ADVANCED CARDIOVASCULAR INTERVENTIONS PA

Dr. Hamid M. Nia, F.A.C.C

20 Prospect Ave, Suite 600

Hackensack, NJ 07601

Phone: 201-265-5700 Fax: 855-265-7385

I authorize (**ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA**) to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Dated Witness

_____ _____

Signature of policyholder Patient or Guardian

Advanced Cardiovascular interventions, PA

20 Prospect Ave, Suite 600

Hackensack, NJ 07601

ERISA AUTHORIZED REPRESENTATIVE FORM

I hereby designate, authorize, and convey to Advanced Cardiovascular Interventions, PA to the fullest extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives to obtain all relevant information on my behalf including but not limited to the summary plan description. I understand I can revoke this authorization in writing at any time. I direct all reimbursable medical payments go directly to you, my medical provider. In the event the Insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the Insurance carrier to pay you directly and monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my Insurer, immediately upon verbal request, all information regarding last payment made my said insurer on my claim, including date of payment and balance of benefits remaining as well as all other relevant documentation including nut not limited to the summary plan description.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Signature Date

_____

Print Name

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Authorization to Release Your Medical Records From Our Office

Patient's Full Name: Patient's Date of Birth

Patient's Social Security Number/Medical Record Number

Address

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

ADVANCED CARDIOVASCULAR INTERVENTIONS, PA - Dr.Hamid M. Nia

2. The following person (or class of persons) may receive disclosure of protected health information about me:

His/her/its Name

Address, City, State Zip Code

3.The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *_____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

4.I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5.I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6.My purpose/use of the information is for _____.

7.This authorization expires on _____, 20___, OR upon occurrence of _____.the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

_____ _____

Signature of patient* Date of patient's Signature

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Authorization to Release Your Medical Records From Other Providers

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/ person/ facility/entity listed below.

Patient Name: _____Date of Birth: _____

The information you may release subject to this signed release form is as follows:

__Complete Records

__History & Physical

__Progress Notes

__Care Plan

__Lab reports

__Radiology Reports

__Pathology Reports

__Treatment Record

__Operative Reports

__Hospital Reports

__Medication Record

__Other (Please specify below)

Release my protected health information to the following physician/ person/ facility:

Advanced Cardiovascular Interventions, PA

6-20 Plaza Rd. Fair Lawn, NJ 07410

20 Prospect Ave. Suite 809 Hackensack, NJ 07601

P: 201-265-5700 F: 855-265-7385

_____ _____

Patient's Name Date

_____

Patient's Signature

_____

Name of Personal Representative (and description of relationship to patient)

_____

Signature of Representative

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

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* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

dobiihcaparb 07/06

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by [ ] and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

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Denied Claim Patient Appeal Level One

Date: _____

_____

_____

_____

Patient: _____

DOB: _____

Member ID: _____

Date of Service: _____

To Whom It May Concern:

I have received correspondence from your company that my claim for services has been denied as not necessary. I am filing an appeal of these denied fees in expectation of eligibility and that your company will provide "good faith" administration of my benefits.

Advanced Cardiovascular Interventions, PA / Dr. Hamid Nia provides me with a comprehensive level of care and coordination of treatment warranted by my medical needs. X-rays and all necessary documentation were provided with the submitted claim. They clearly support the level of service provided.

What is your definition of "good faith"? Would you question your well-trained, licensed doctor who is personally involved with your care when evidence exists to support their treatment plan and my policy does not exclude such care?

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To you, this may be just another claim. To me, it is my medical care needs and I pay for coverage for those needs. Are you suggesting I cut corners in my medical care needs and in doing so jeopardize my health care? Is your company or reviewing professional willing to absorb any financial and legal liability for my future medical and health care needs that may be affected by your refusal of coverage? If additional information is required, please advise me promptly what specifically is required and for what purpose.

If you are prepared to deny these services, please provide me with dated and documented criteria and research that establishes your position. I am also requesting the name and credentials of the peer professional who reviewed my records and any conflict of interest in that professional who is making the determination of eligibility of services (such as, are they on your payroll?) and what they reviewed and in what format did they review it.

I am prepared to initiate a complaint process to the State or Federal agency that oversees my right to fair claims administration.

I await your reply,

_____ _____

Member Signature Date

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Financial Agreement

We, the staff of **Advanced Cardiovascular Interventions, PA / Dr. Hamid Nia** thank you for choosing us as your medical provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, and in-state checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest

Interest will incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of

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services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee may apply. These fees include $100 for a missed office visit, $50.00 per ultrasound/echo, and $250.00 for nuclear stress tests, but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

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Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____

aetna℠ Authorized Representative Request

FAX Number

Member Name	Aetna ID Number
Provider of Service	
Name and Dates of Service or Proposed Service	

I, _____, do hereby name
Print the name of the member who is receiving the service or supply

_____
Print the name of the person who is being authorized to act on the member's behalf

to act as my authorized representative in requesting *(check one)* ☐ a complaint or ☐ an appeal from Aetna regarding the above-noted service or proposed service.

IMPORTANT: Your signature below means that you understand and agree to the following:

- In conjunction with this *(check one)* ☐ complaint or ☐ appeal, Aetna may disclose Protected Health Information ("PHI") to the above-named authorized representative ("Representative").
- **The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.**
- Information disclosed pursuant to this authorization may be redisclosed by the Representative and may no longer be protected by federal or state privacy regulations.
- If you would like to pursue *(check one)* ☐ a complaint or ☐ an appeal, at the Representative's request, but do **not** want the Representative to receive any PHI or other information related to the *(check one)* ☐ complaint or ☐ appeal, including the *(check one)* ☐ complaint or ☐ appeal, decision, you may indicate that choice by checking the box on the signature line below.
- Your ability to enroll in an Aetna plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. However, without your signature, we cannot process the *(check one)* ☐ complaint or ☐ appeal, initiated by the Representative.
- This authorization is only valid for the duration of the *(check one)* ☐ complaint or ☐ appeal. If you sign this form, you may revoke the authorization at any time by notifying Aetna in writing at the address above. Revoking this authorization will not have any effect on actions that Aetna took in reliance on the authorization before we received the notification.

☐ Please accept this *(check one)* ☐ complaint or ☐ appeal, from my representative on my behalf; however, forward all information related to this *(check one)* ☐ complaint or ☐ appeal, including the *(check one)* ☐ complaint or ☐ appeal decision and any request you may have for additional information, to my attention only.

Signature	Date
Print Name	
If person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a Member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority.

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Welcome to our office!

Date: _____

PATIENT'S NAME:		S.S#		SEX: M F	BIRTH DATE: AGE:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	RELIGION:	
HOME PHONE NUMBER:		CELL PHONE NUMBER:		MARITAL STATUS: S M W D SEP	
DRUG ALLERGIES, IF ANY		EMERGENCY CONTACT (Name, phone number & relationship to patient):			
ETHNICITY	PREFERRED LANGUAGE:		RACE(S):		
E- MAIL:		PHARMACY (name, town or number):			
PATIENT'S OR PARENT'S EMPLOYER:		OCCUPATION (INDICATE IF STUDENT):		HOW LONG EMPLOYED:	
EMPLOYER STREET ADDRESS:		CITY AND STATE:	ZIP CODE:	BUS.PHONE # EXT. #	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

RESPONSIBLE PARTY NAME:	RELATIONSHIP TO PATIENT:		BIRTH DATE:
*RESPONSIBLE PARTY STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	HOME PHONE #:
PRIMARY INSURANCE NAME:	INSURANCE ID #:		GROUP #:
NAME OF POLICY HOLDER:	BIRTH DATE:		PLAN NAME:
INSURANCE ADDRESS:	CITY AND STATE:	ZIP CODE:	PHONE # EXT. #
SECONDARY INSURANCE NAME:	INSURANCE ID #:		GROUP #:
NAME OF POLICY HOLDER:	BIRTH DATE:		PLAN NAME:
INSURANCE ADDRESS:	CITY AND STATE:	ZIP CODE:	PHONE # EXT. #

PATIENT'S REFERRAL INFORMATION

Primary Care Physician _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State _____ Zip _____

Referring Physician _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State _____ Zip _____

Please Read and Sign this Form:

I hereby authorize my insurance benefits to be paid directly to Hamid M. Nia, M.D. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

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Date: ____________________

NAME: ____________________________________   D.O.B.: ____________________

MEDICATION LIST:

NAME	DOSAGE	DIRECTIONS

Name: _____ **Today's Date:** _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____