HOWARD S. MITZ, D.O.
220 Cottage Street
Littleton, NH 03561
(603) 444-0272

REGISTRATION
(Please Print)

PATIENT INFORMATION

Date _____ Cell Phone _____ Home Phone _____

Name _____ Soc. Sec.# _____
Last First Initial required for insurance

Physical & Mailing Address _____

City _____ State _____ Zip _

Sex: Male _____ Female _____ Age _____ Date of Birth _____

Marital Status:
__Cohabitate __Divorced __ Married __ Separated __ Single __Widowed

Employed by _____ Occupation _____

Business Address _____ Phone _____

Pharmacy _____ Whom may we thank for

referring you? _____

Who is your primary care physician? _____

In Case of emergency who should be notified? _____
(Name, phone and relationship)

ASSIGNMENT AND RELEASE

I certify that I or my dependant has insurance coverage with _____and assign directly to Dr. Howard S. Mitz all insurance benefits. I understand that I am financially responsible for all charges incurred if a required referral from a PCP is not provided to Dr. Mitz. I understand that I am financially responsible for all charges that are not covered by my insurance plan. I authorize the use of this signature on all insurance submissions.

***Any charges not paid in full which are submitted to small claims or an outside collection agency will incur collection fees and will become the patient or legal guardians responsibility.**

_____
(Patient or Legal Guardian Signature)

NORTH COUNTRY GASTROENTEROLOGY
OFFICE ENDOSCOPY
DR. Howard S. Mitz, D.O. FACOI
220 Cottage Street
Littleton NH 03561
PH: (603)444-0272 Fax: (603)444-0274

Authorization for Release of Medical Records

Date_____ Date Request Sent:_____INT:_____

Patients Name_____ Date of Birth_____

Release From_____ Phone#_____

Address_____ Fax #_____
_____
_____

I hereby authorize and request exchange of information (verbally or in writing) between North Country Gastroenterology, Dr. Howard S. Mitz, D.O. at 220 Cottage Street, Littleton NH 03561

Please send all information related to Gastroenterology / including the following:

( ) Patient chart summary ( ) Current Medications ( ) Lab Results
( ) Colonoscopy Reports ( ) EGD Reports ( ) Pathology Reports
( ) Imaging Reports ( ) Other _____
_____

The purpose of this request is to expedite medical treatment and or sharing of care.
Dates ( ) From_____ To _____ or ( ) Any and All

Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the above information. I understand I may revoke this authorization at any time by notifying NCG in writing, except to the extent that (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the police or the policy itself.

_____ _____
Signature of patient or patients representative Relationship

Dr Howard S. Mitz

Gastroenterology
Patient Medical History and Background for Consultation

Date _____

Patient Name _____
Last First MI

Date of Birth _____ Age _____ Gender at Birth _____ Present Gender _____

Marital Status: __ D __M __S __W Children Y/N If yes, How many _____

Any current problems with or past medical history with:

	Yes	No	If yes, explain
Ears / Hearing			
Eyes / Visual			
Throat / Neck			
Heart / Chest Pain			
Lungs / Shortness of Breath			
Stroke / Seizures			
Headaches / Numbness			
Kidneys / Bladder			
Cancer			
Tuberculosis			
Childhood Diseases			
Rheumatic Fever			
Diabetes/Thyroid/other			
Joint Disorders			
Rashes / Skin Problems			
High Blood Pressure			
Fever / Weight Loss			
Hematology Problems			
Bleeding tendencies			
Other			

Current Medications / Amount:

_____
_____
_____
_____

Current Medications / Amount:

_____
_____
_____
_____

Please continue to next page

Name:_____ **DOB:**_____

Past Surgical History:

Type: Date: Drug Allergies:

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Highest level of education: _____

Occupation / Type of work: _____

Have you smoked? Yes / No # packs per day _____ for # years _____

Used tobacco products or vaped? Yes / No Amount _____

Quit smoking? Yes / No If yes, how many years _____

Ever been out of the USA? Yes / No If yes, when and where _____

Ever been hospitalized? Yes / No Could you be pregnant? Yes / No

PAST FAMILY HISTORY:

Mother: Alive or Deceased Age __ Illnesses _____

Father: Alive or Deceased Age __ Illnesses _____Number of Sisters

_____ and/or Brothers _____ Illnesses _____

Have any of your blood relatives ever had:

Cancer _____ Who _____ High Blood Pressure _____ Who _____

Diabetes _____ Who _____ Intestine Problems __ Who _____Heart Trouble

Who _____ Liver Disease _____ Who _____

Malignant hyperthermia _____ Who _____

THANK YOU VERY MUCH FOR YOUR COOPERATION IN SUPPLYING ME WITH THE ABOVE INFORMATION. IT WILL HELP WITH YOUR CONSULTATION.

Date _____

Howard S. Mitz, D.O. _____

NORTH COUNTRY GASTROENTEROLOGY
HOWARD S. MITZ, D.O.FACOI
220 Cottage Street
Littleton, NH 03561
PH. (603) 444-0272 FAX (603) 444-0274

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW. Please cross out any of the below if you do not want us to obtain or share your information.

Patient Name:

Patient's Date of Birth: **Patient's SSN:**

A. Person(s) or Organization(s) authorized to provide the information: ***Current or past healthcare providers, healthcare facilities*** *(hospitals, labs, x-ray dept, medical records)****, insurance co***.

B. Person(s) or Organization(s) authorized to receive the information: ***Current or past healthcare providers, healthcare facilities, insurance co.***

C. Specific description of the information that may be used or disclosed: ***All relevant healthcare information, including all relevant dates.***

D. Specific description of how the information will be used: ***Continuation of your healthcare.***

E. May we leave messages at: ***home*** (yes / no), ***work*** (yes / no), ***or on answering machines*** (yes / no).

F. May we speak to family members or individuals involved with your care (yes / no). **List names and phone numbers below and relationship.**

Please continue to next page

1. I understand that this authorization will not expire unless a date is given _____.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying North Country Gastroenterology in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

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

Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information").
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care providers(s).
You have the right to know who is going to use the information and what it is going to be used for (e.g., John Smith, PhD/Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information
This form does not constitute legal advise and covers only federal, not state, laws

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

O The patient refused to sign.
O Due to an emergency situation it was not possible to obtain an acknowledgement.
O We weren't able to communicate with the patient.
O Other (Please provide specific details)

Employee signature *Date*

PATIENT'S COPY

NORTH COUNTRY GASTROENTEROLOGY

HOWARD S. MITZ, D.O.FACOI

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 03/10/03 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes where made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, *Alana Quillin*. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to your. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence, and other State and Federal official and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. The information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibility: We will disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

PATIENT'S COPY

HIPAA Notice of Privacy Practices

This form does not constitute legal advise and covers only federal, not state, law.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards or letters.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.50 for each page and the staff time charged will be a $10.00 per hour fee including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: Your have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available). You have the right to a list of instances in which we or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available).

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: ***North Country Gastroenterology; Dr. Howard S. Mitz, D.O.***

Address: ***220 Cottage Street, Littleton NH 03561***

Telephone: ***(603) 444-0272*** Fax: ***(603) 444-0274***

Privacy Officer: ***Alana Quillin***

PATIENT'S COPY

NORTH COUNTRY GASTROENTEROLOGY
220 Cottage Street
Littleton NH 03561
PH (603) 444-0272 Fax (603) 444-0274

HOWARD S. MITZ, D.O. FACOI **GASTROENTEROLOGY**
OFFICE ENDOSCOPY

Patient Accounts and Broken Appointment Policy
for medical services

INSURANCE CARDS

Patients are required to provide the receptionist with their insurance card at each visit or as requested

Receptionists are required to verify the patients insurance eligibility and primary care physician (PCP) prior to each visit and to determine any required service co-pay.

Patients who do not present an insurance card may be referred to the office manager and may be required to make full payment for payment for services at the time of the visit, or may be refused their appointment time for routine medical care.

INSURANCE CO-PAYS AND DEDUCTIBLES

Patient co-pays are due at time of service

Patients will be reminded to bring their co-pay with them when an appointment is made and again of a confirmation telephone call is made.

Reception staff will ask all patients how they wish to pay for their co-pay when they arrive for their appointment. We accept cash, check, credit card payment.

Patients who are not willing to make their co- payments at time of service will have a $35.00 charge added to their account. the nonpayment fee will be waived if the co-pay is received before billing statements are sent out for that month.

Patients insurance & benefits will be verified prior to procedures, including patient deductible, co-insurance, etc.

Expected patient balances up to $500.00 are required to be paid in full prior to procedures; all patients with expected balances over $500.00, including ACHS patients, must have 50% of the procedure cost paid 3 work days prior to the procedure & 50% after 1st statement. (example: $500.01 - $2000.00 deductible, 50% of expected patient responsibility are to be paid 4 work days prior to procedure.) If patient doesn't pay the 50% the procedure will be cancelled or rescheduled, unless another payment agreement has been arranged with our office.

PATIENT'S COPY

PATIENT BALANCES

Payment for all services is the responsibility of the patient or their guarantor.
As a courtesy to our patients we will bill many insurance companies prior to billing the patient.

Patients are expected to pay any balances which they owe upon receipt of a billing statement from this office.

Patients with delinquent unpaid balances which are 90 days or more overdue (individual or family) may not be permitted to schedule non-emergent medical appointments until payment arrangements have been made with the patient accounts representative. In addition, patients with overdue accounts may be released from our medical practice unless they are actively making payments. Payment plans will be structured to pay off all balances within 6 months. Decisions to release a patient from our practice must be reviewed and decided by Dr. Mitz. Patients released from our practice will receive 30 day notification and will be seen for emergencies during that time, Any fees incurred to collect payment on accounts will be added to the account balance and become the patient or guardians responsibility.

Patients who have been released for delinquent accounts may be accepted into the practice again once all outstanding medical patient account balances have been paid. It will be required that these patients pay for medical service prior to seeing Dr. Mitz.

APPOINTMENTS MISSED WITHOUT NOTICE

In order to serve all our patients we will take the following actions when appointments are missed repeatedly (3 instances within a 12 month period) without adequate advance notice to the office staff. Adequate notice is defined as a minimum of 24 hours prior to the appointment. The office manager will consider the reasons for a missed appointment prior to categorizing as "missed without notice".

First and second occasions: Patients will receive a follow up telephone call or letter from the office staff or provider requesting a reason for the missed appointment and to reschedule the appointment.

Third occasion: There will be a $40.00 missed appointment fee due and patients will lose the privilege of making advance medical appointments and will be permitted to make appointments only on the day of service if appointments are available. (reasons for the missed appointment, especially the patients medical condition, will be considered prior to charge for missed appointment fee and/or restricting advance appointment privileges).

This office reserves the right to suspend, either indefinitely or for a prescribed period of time from the medical practice any patient who habitually misses appointments. Decisions to release a patient from this practice must be reviewed and decided by Dr. Mitz. Patients released from the practice will receive 30 day notification and will be seen for emergencies during that time.

APPEALS

Patients may appeal decisions IF released from this practice by sending a written request to Howard S. Mitz, D.O. at 220 Cottage St, Littleton NH 03561, stating the reasons why the decision should be reviewed. The office staff and Dr. Mitz will review the patients request and discuss the circumstances and then communicate a decision to the patient.