IDEAL MEDICAL CARE OF NEW YORK, PLLC

Registration Form 2020

Today's date: ____/___/____

Name: Last_____________________________, First___________________________, MI ____

Birth date: _____/____/_____ **Birth Sex:** M ☐ / F ☐ **Social Security number**: ___________________

Home Address: Street____________________________, City__________________, State:_______, zip:____________

Phone: Cell: _______________________, Home: ________________________, Job: ___________________________

E-Mail Address: _________________________________ **@** __________ **. COM**

Emergency Contact 1: Name: ________________________Phone: _____________________ Relation: ___________

Do you permit us to share your medical information with this person: Yes ☐ / No ☐

Emergency Contact 2: Name: ________________________Phone: _____________________ Relation: ___________

Do you permit us to share your medical information with this person: Yes ☐ / No ☐

Demographics: Race: Asian☐, Black☐, White☐, Hispanic or Latino☐, Native Hawaiian☐, Other____

Ethnicity: Latino or Hispanic☐, Non-Latino or Non-Hispanic☐, Other________________

Occupation: ______________ **Marital Status**: ____________________

Religion: ______________ **Preferred Language**: ______________

Smoking status: Never☐, Formal smoker☐, Daily☐, Occasionally☐

Special Need: None☐, Cane☐, Wheelchair☐, Homebound☐, Blind☐, Deaf☐

<u>Tele-Health</u> allows me to have video or phone appointments with my Dr. I have read the details on the next page of this form and I am giving consent for it: **Yes** ☐ **/ No** ☐

<u>Appointment Cancellation & No-Show policies</u>: I have read the office policies related to appointment cancellations or no-shows penalties on the next page.

Pharmacy: Name: ____________________, City: ________________, Zip: __________, Phone: ___________________

Insurance Information: ☐ **No Insurance**

Primary Insurance: Ins. Company: ____________________, ID #:_________________, Group #:____________

Policy holder's name: Last_________________________, First___________________________, MI_______

Relation to the patient: ________________, Birth date: _______________ S.S#:______________________

Address: Street_________________________________, City: ________________, State: _____. Zip: _____

Employer's name: ___________________________ , Employer's phone: _____________________________

Additional Insurance: Ins. Company: ____________________, ID #:_________________, Group #:____________

<u>Please read the next page carefully for our policies/info and then sign here:</u>

Patient's Signature: __________________________ , Date: ________________________

Parent/guardian's Name: ___________________ ___, Relation: ____________, Signature: ______________

Office Appointment & No-Show Policies:

No Show or Late Cancellation:

[We request at least 24-hour notice to cancel or reschedule an appointment. Please call us during office hours to cancel or reschedule. Not informing/Late-cancellation/Leaving messages on answering machine are considered as "No Show" and you will be charged a $50.00 **fee**. This fee is not paid by your insurance company. You are responsible to pay it. After three "no-shows" in a calendar year, we have the right to dismiss you from our practice.
Walk-in appointments are for URGENT medical matters only. Appointments are required for non-urgent matters]
I have read & agree with the above office appointments policies.

Advance Beneficiary Notice (ABN) & Agreement:

I hereby authorize IDEAL MEDICAL CARE OF NEW YORK, PLLC., the physicians (including covering physicians) and other medical staff to provide such medical care and treatment, including immunizations, as deemed necessary or advisable at each encounter. I acknowledge that no assurances have been made concerning the results from any services that I will receive from IDEAL MEDICAL CARE OF NEW YORK, PLLC.
I authorize payment directly to IDEAL MEDICAL CARE OF NEW YORK, PLLC. for the services. I understand that I am financially responsible for all charges not covered by the insurance including services, supplies and copayments/deductibles. I am responsible to know how my plan works and I acknowledge responsibility for any payment denied due to seeing a provider out of network or due to incomplete or inaccurate information provided.
Advance Beneficiary Notice (ABN): (Physician/PA at Ideal Medical Care of New York, PLLC. may sometimes offer/deliver services/procedures/tests that he/she may determine to be 'reasonable and necessary' based on the information available. If, under Medicare or other insurance's standards your diagnosis does not support these services/procedures/tests, Medicare/other insurance will deny coverage. In such cases the billing will be forwarded to you and you will be responsible for the cost of these services, not the physician or the company). In such a case I agree to be personally and fully responsible for the payment.

Tele-Health/Virtual Care:

(It means VIDEO & PHONE APPOINTMENTS and PORTAL/TEXTING communications. IT GIVES EASE OF ACCESS BETWEEN THE PATIENT AND HIS OR HER PHYSICIAN. WHEN NEEDED YOU CAN GET MEDICAL HELP FROM THE COMFORT OF YOUR HOME. This can be initiated by the patient or by the provider)
I understand that Tele-health is not for life-threatening emergencies. In such cases 911 should be called. I understand that INSURANCE eligibility/rules/policies/fee apply. I agree to be responsible for the cost of the fees associated with Virtual Visits that are not covered by insurance or third party payment, including copays and deductibles.

Acknowledgment of Receipt of Notice of Privacy Practices: (HIPAA)

(Notice of privacy practices explains how we may use/ disclose your protected health information and what are your rights in this regard. It's available in the waiting room, by the receptionist desk and online @ Idealmedicalcare.net for your convenience)
I have reviewed this practice's Notice of Privacy. I have been given the opportunity to ask questions in this regard to fully understand it.

Certification: I confirm that the above information has been read by me / above information has been explained to me on request, and that I fully understand all of the above.
I certify that all the information given by me is complete and accurate to my knowledge.
In case of minors / dependents, I certify that I am the legal guardian and grant permission to receive services offered by Ideal Medical Care of New York, PLLC.

After reading the above carefully, please sign on the previous page.

IDEAL MEDICAL CARE OF NY, PLLC (Hx Summary)

Your Name: ______________________________________ **Date:** ____________________

Have you or your close family members ever been diagnosed with: (check: √)

	Self	Family
High Blood Pressure		
High Cholesterol		
Diabetes		
Heart problem		
Stroke		
Anemia		
Cancer		
Blood disease / clots		
Thyroid problem		
Liver problem / Hepatitis		

	Self	Family
Prostate Problem		
H/O TB/PPD +		
Kidney problem		
Glaucoma		
Asthma / lung problem		
Epilepsy / Seizers		
Stomach Ulcer		
Osteoporosis		
HIV / STDs		
Psychiatric problems		
Fractures		

Other Problems:____

____

Allergies: ☐ No known allergy to any medicine

☐ Allergy to medicine:

Medicine	Reaction

☐Other important allergies/reactions:

____

____

____

Medicines that you take regularly: (including OTC meds, vitamins, herbal medicines) **None:** ☐

Name of the medicine:	Strength	How many times a day

Please mention Surgeries/Procedures or Hospitalizations: **None:** ☐

☐Appendix removed, ☐Gall bladder removed, ☐Dental Surgery, ☐Any Biopsy, ☐Cataract Surgery
☐Uterus /Ovaries removed, ☐Tube Tied, ☐C/Section,
☐Heart Surgery, ☐Stent placement, ☐Stress test, ☐Angiogram, ☐Blood transfusions
☐Colonoscopy, ☐Upper Endoscopy

Other Surgeries: ____

Details: ____

____

Social History:

Your education: ____________________ Your occupation: _________________________
Married☐, Single☐, Divorced☐, Separated☐, Widow/widower☐, Never had sex☐
Living Arrangement: Living alone☐, Living with _______________
Do you smoke? Yes ☐ How much? (_____cig in a day) / How long? Since ____years.
Never Smoked☐ Quit smoking _______months/years back.
Do you take alcohol? No ☐ / Yes ☐ How much? ___________________________________
Any illicit drug use? No ☐ / Yes ☐ Names:_______________________________________
Tattoos /body piercing? No ☐ / Yes☐ (Describe locations & images): ______________________________

____

Write down the YEAR you had the following vaccines:
Tetanus ________, Pneumonia ________, MMR ________, ________ Varicella:_______, _________
Hepatitis A _______, _________ Hepatitis B__________, _________ , ____________

For Females:
First day of your last Menstrual Period: __________________
☐ Pregnant ☐ Breast feeding ☐ Birth control pills / Female Hormones
☐ Post Menopausal ☐ Have IUD now.

Total number of pregnancies: _____
Number of abortions / miscarriages: _____
Number of living children: _____

Date of last Pap Smear: ____________________ Result: ☐ Normal / ☐Abnormal
Date of last Mammogram: __________________ Result: ☐ Normal / ☐Abnormal
Date of last Bone Density test: _______________ Result: ☐ Normal / ☐Abnormal

Note:
- It is always advisable to choose a healthcare proxy who can make healthcare decisions on your behalf if you become unable to do so on your own. Please inform the doctor if you are interested in doing so.
- If you have any other health issues, please discuss with your doctor.

Patient/Guardian's Signature: ________________________

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Ideal Medical Care of NY, PLLC** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ **1. I GIVE CONSENT** for **Ideal Medical Care of NY, PLLC** to access ALL of my electronic health information through Healthix to provide health care.
☐ **2. I DENY CONSENT** for **Ideal Medical Care of NY, PLLC** to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call **Ideal Medical Care of NY, PLLC** at 516-285-4356 ; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.