The Doctor's Office

Family Practice and Immediate Care

Please complete all sections of this form to the best of your ability.

Patient's Name: _____

Patient's Date of birth: _____

List ALL Food and Medication Allergies:

_____ _____

_____ _____

_____ _____

List All Medications, Supplements, Vitamins, and Dosages: If you have a preprinted medication list please fill out this section and provide your preprinted list. If you do not take any medications state **NONE.**

_____ _____

_____ _____

_____ _____

Medical Problems: Please list all past and present medical problems, if you do not have any past or present medical problems state **NONE.**

_____ _____

_____ _____

_____ _____

Previous surgeries and hospitalizations: Please include dates if possible.

_____ _____

_____ _____

_____ _____

When was your last **TETANUS** vaccination? _____

When was your last **PNEUMONIA** vaccination? _____

If you are over age 50, have you received the vaccination against **SHINGLES**? If so, When? _____

The Doctor's Office
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PATIENT INFORMATION

Patient's Last Name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Cell phone no.: ( )

P.O. Box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Home /Alternative Phone Number: ( ) Pharmacy Information: Pharmacy Name: Pharmacy Address: Phar.# ( )

Provide Email Address For EMR Patient Portal Access:

INSURANCE CARRIER(S) INFORMATION

Policy Holder: Insurance Carrier: Address: City

State and Zip code

Policy ID #: Group # : Policy Holder Name and DOB: Policy Holder SS#:

Patient's relationship to Secondary Insurance: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate Secondary insurance:

Policy ID #: Group #: Policy Holder DOB: / / Policy Holder: Policy Holder SS#: Policy Holder Employer:

Patient's relationship to Secondary Insurance: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Home phone no.: ( ) Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Doctors Office Family Practice and Immediate Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

The Doctor's Office
Family Practice and Immediate Care

ASSIGNMENT OF BENEFITS

I ASSIGN PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESSTHE CLAIM AS WELL AS RELEASE OF INFORMATION TO AID IN MY TREATMENT. I AM AWARE THAT THERE IS A PRIVACY STATEMENT ON FILE IN THE OFFICE, FOR MY VIEWING. I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANYTIME.

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT ALL SERVIES RENDERED TO ME WILL BE BILLED TO MY INSURANCE COMPNAY IN ANY MANNER THAT IS TRUE AND NOT FRAUDLENT THAT WILL HELP SECURE PAYMENT. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY SERVICES RENDERED THAT ARE DENIED OR REMAIN UNPAID BY MY INSURANCE COMPANY. FAILURE TO PAY COPAYMENTS AT THE TIME OF THE VISIT, WILL BE AN ADDITIONAL CHARGE OF $10.00.

I UNDERSTAND THAT I AM RESPONSIBLE TO NOTIFY THE DOCTORS STAFF IS A SPECIFIC LAB IS NEEDED FOR MY INSURANCE OR IF I HAVE A CHANGE OF INSURANCE. WILL NOT BE RESPONSIBLE FOR VISITS TO OTHER PHYSICIANS FOR WHICH A REFERRAL HAS NOT BEEN GENERATED.

IF THE PHYSCIAN IS NOT SELECTED AS YOUR PRIMARY CARE PHYSICIAN ON YOUR INSURANCE YOU WILL BE HELD RESPONSIBLE FOR PAYMENT ON ALL CHARGES.

Signature _____ Date _____

ATTN: MEDICARE PATENTS

PLEASE NOTE THE FOLLOWING INFORMATION REGARDING NON-COVERED SERVICES.
The labs and medicare have notified us that they deny certain lab tests we perform. You may be responsible for payment of certain lab tests.

ALL PATIENTS

PLEASE NOTE THAT OUR OFFICE IS NOW OFFERING EXPANDED MEDICAL SERVICES, SUPPLIES, AND SUPPLEMENTS THAT ARE NOT COVERED BY INSURANCE OR MEDICARE. THEREFORE, I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT AT THE TIME OF THE VISIT

Signature _____ Date _____

The Doctor's Office
Family Practice and Immediate Care

389 Merrick Ave, Merrick, N.Y. 11566

(P) 516-867-5132

(F) 516-867-5519

INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES

In consideration of services rendered by The Doctors Office to the undersigned patient, the undersigned promise(s) to pay The Doctor's Office for any copayment, coinsurance, or other charges required to be paid by the patient's health insurance. In addition, the patient (or responsible party) agrees to pay for all services that are not covered by the patient's health insurance plan.

I/we also authorize The Doctor's Office to release to the patient's insurer, third party payer, HMO, appropriate government agencies, and/ or to whoever is financially responsible for the patient's medical care all information needed to substantiate payment for such medical care.

Patient's Name:

_____

Signature of Patient or Authorized Representative:

_____

Today's Date:

_____

The Doctor's Office
Family Practice and Immediate Care

389 Merrick Ave, Merrick, NY 11566
516-867-5132 (P)
516-867-5519 (F)

Patient Portal Policy

We are now inviting patients into our electronic patient portal, to your convenience you will now have access to your medical records such as lab results, etc. You will also be able to view bills and make online payments.

There is an option to contact staff and the doctors via email which will not be utilized. This patient portal is strictly for access to your medical records only. It is not for communication purposes.

By signing this policy consent, you are aware that the patient portal is for medical records and billing purposes only. The staff and doctors will not respond to any messages or emails. Please continue contact the office for any other medical concerns. We appreciate your cooperation, if you have any questions or concerns please feel free to contact us or inquire at the front desk.

Patient Signature: _____ Date: _____

Email: _____

NOTICE OF PRIVACY PRACTICES

Effective date: 3/10/2014

Notice of Privacy Practices
As required by the privacy regulations created as a result of the health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY:

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We also are required by low to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the teems of the notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Dr. Mark Haltrecht @ The Doctor's Office Family Practice and Immediate Care - 389 Merrick Ave, Merrick, NY 11566
516-867-5132 • fax: 516-867-5519

C. We may use and disclose your PHI in the following ways:

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer

to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if y9uor insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. **Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. **Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

Except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal rsik to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other p;erson or entity (except as required by law) for authorized oversight of the research study, or fo other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

9. Serious threats to health or safety. Our practice may use and disclose your PGI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

10. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

11. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your PHI to federal and

national activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

12. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

13. **Workers' compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with your about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate *reasonable* requests. You do not need to give a reason for your request.

2. **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or other health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however,

if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566**. You must provide us with reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which

you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of disclosures.** All of our patients have the right to request an "accounting" of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures or practice has made of your PHI non related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566.** All requests for an "accounting fo disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566.**

7. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566. All complaints must be submitted in writing. You will not be penalized for filing a complaint.**

8. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

I consent to receive calls from The Doctor's Office Family Practice and Immediate Care for my protected health information and other services at the phone number(s) I have provided to the practice. I understand I may be charged for such calls by my phone and wireless carrier and that such calls may be generated by an automated dialing system. I understand that I may revoke my authorization to receive further calls or messages at any time, and such revocation does not have to be in writing.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact
The Doctor's Office Family Practice and Immediate Care, 389 Merrick Ave, Merrick, NY 11566.

_____

Today's Date: _____

Patient's Name: _____

Patient's Authorized Representative's Name (if necessary)

_____

Signature of Patient or Patient's Authorized Representative

_____