Patient Information **(Please fill out ALL information/ Please print clearly)**	ACCT #_____ FOR OFFICE USE ONLY

LEGAL LAST NAME	LEGAL FIRST NAME	MI
PREFERRED NAME		
ADDRESS	APT	
CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY #	
EMAIL ADDRESS		

Please **CHECK** one Preferred Contact Number: ❑ HOME (_____) _____-_____ ❑ CELL (_____) _____-_____ ❑ OFFICE (_____) _____-_____	Please **CHECK** one Preferred Spoken/Written Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Other: _____
Please **CHECK** one Gender Identity: ❑ Male/Man ❑ Female/Woman ❑ TransMale/TransMan ❑ TransFemale/TransWoman ❑ Genderqueer/Gender nonconforming ❑ Other:_____	Please **CHECK** one Preferred Pronoun: ❑ He ❑ She ❑ They ❑ Other: _____
Please **CHECK** One Race: ❑ White ❑ African American ❑ Asian ❑ Pacific Islander ❑ Other Race	Please **CHECK** One Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Other: _____

EMERGENCY CONTACT NAME	
RELATIONSHIP TO CONTACT	PHONE # TO CONTACT (_____) _____-_____

EMPLOYER'S NAME	OCCUPATION	
EMPLOYER'S ADDRESS		
CITY	STATE	ZIP

REFERRED BY	REASON FOR VISIT

ANY Copay OR Due Balance payment is due at the time of service. Accepted forms of payment are CASH, CHECK, MONEY ORDER, CREDIT CARD OR ONLINE @ WWW.INSTAMED.COM.

I authorize payment of medical benefits directly to the physician. I further authorize the release of any information necessary to process these medical claims. Policy Notice of this office is to bill any MISSED appointments unless given at least 24 HOURS notice. I understand that unless I have given such notice, I will be CHARGED the rate of the providing physician.

_____
Signature of Patient

_____/_____/_____
Date

Insurance Information (Please fill out ALL information/ Please print clearly)	ACCT #_____ FOR OFFICE USE ONLY

Please **CHECK** one as your INSURANCE:

- ❑ PRIMARY
- ❑ SECONDARY
- ❑ TERTIARY

INSURANCE COMPANY

Member ID #

Group #

Please **CHECK** one Your **Relationship** to Subscriber:**(If SELF,skip down to BOX regarding Responsible Party OR If check off other options please fill out Subscriber's info below this box)**

- ❑ Self
- ❑ Spouse
- ❑ Child
- ❑ Life Partner
- ❑ Other: _____

Subscriber's Last Name _____ First Name _____ MI_____
Subscriber's Date of Birth _____/_____/_____ Subscriber's Phone # (_____) _____
Subscriber's Address _____ Apt _____
City_____ State _____Zip_____
Sex of Subscriber Please **CHECK** one Gender Identity:

- ❑ Male/Man
- ❑ Female/Woman
- ❑ TransMale/TransMan
- ❑ TransFemale/TransWoman
- ❑ Genderqueer/Gender nonconforming
- ❑ Other:_____

Responsible Party Please **CHECK ONE**: (Person Responsible for **ANY** due Balances)

- ❑ Self
- ❑ Spouse
- ❑ Other: _____

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I authorize payment of medical benefits directly to the providing physician. I further authorize the release of any information necessary to process these medical claims. I understand that I am financially responsible for ALL deductibles, co-payments, referrals, non-covered services (such as (but not limited to) Yearly Physical, Office Visits, Vaccines, Medications, etc.) which may apply as directed by my insurance plan. For questions about your coverage, please contact your insurance company directly. If my insurance plan does NOT cover these cost, I AGREE TO PAY for these services.

_____
Signature of Patient

_____/_____/_____
Date

CREDIT CARD INFORMATION

We are asking you to provide a **credit card** for us to have on file. This information will be held securely in your medical record. If your insurance requires you to meet an annual deductible before they pay, you will be billed for services rendered until you meet your deductible. Upon meeting your deductible, you are responsible for any coinsurance or copayments.

Once your insurance has paid their portion and notified us of your share, ONE statement will be sent to your mailing address on file. If no response is received, we will charge this card for your due balance 30 (thirty) days from the statement date.

Please note that this will not compromise your ability to dispute a charge or your insurance company's payment.

Please familiarize yourself with your insurance company's current practices and procedures.

NAME ON CARD:_____

PLEASE **CHECK** one as your **CARD TYPE**:

- ❑ MASTERCARD
- ❑ VISA
- ❑ AMEX

CARD NUMBER:_____

EXPIRATION DATE: **MONTH**_____ **YEAR**_____

SEC CODE:_____ **BILLING ZIP:**_____

SIGNATURE_____ DATE _____/_____/_____

_____Please **INITIAL** if you prefer **NOT** to receive a statement before having your card charged for any balances owed. It is always recommended to leave a **credit card** rather than a debit card on file.

ACCOUNT #_____
FOR OFFICE USE ONLY

Krisczar J. Bungay, M.D. **Irina Linetskaya, M.D.**

Stephen M. Dillon, M.D. **Jeffrey Kwong, N.P.**

Tom Saglimbeni, N.P. **Samantha E. Fleischman, N.P.**

Aimin Ouyang, P.A.-C

314 W 14th Street, 5th Floor
New York, NY 10014
Phone (212) 620-0144/Fax (212) 691-8588

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, orally, or on paper is kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared the explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, and managing your healthcare and related services by one or more healthcare providers. An example of this would include physical examination.
- **Payment** means such activities as obtaining reimbursements for services, confirming coverage, billing or collection act ivies, and utilization review. An example of this would be sending a bill for your visit to your insurance company.
- **Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our practice manager, David Hathaway (privacy officer).

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative or at alternative locations.
- The right to inspect a copy of your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of our protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003, and we are required to bide by the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You may recourse if your feel your privacy protections have been violated. You have the right to file a written complaint with our office, the Department of Health and Human Services, and/or the Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against your filing a complaint.

For more information about HIPAA or the file a complaint contacts:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave SW
Room 509F, HHH Building
Washington, D.C. 20201
Email: OCRMail@hhs.gov
Toll Free: (800) 368-1019

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza-Ste 3312
New York, NY 10278
Phone: (800) 368-1019
Fax: (212) 264-3039
TDD(800) 537-7697

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New York, NY 10014

Phone (212) 620-0144 / Fax (212) 691-8588

Dear Valued Patient,

We have always believed in maintaining the privacy and confidentiality of our patients' medical information.

Effective April 14th, 2003, we are required to take some additional steps with regard to the privacy of your protected health information (PHI). This is in accordance with the privacy regulations created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please read the Notice of Privacy Practices. This explains in detail how health information about you may be used and disclosed to others. It also explains how you can gain access to your medical records and suggest corrections. You can also request that we restrict disclosure of your PHI.

If you have questions regarding the Privacy Notice, please speak with our office manager, David Hathaway.

Thank you.

I have reviewed and been offered a copy of the Notice of Privacy Practices.

_____ _____

Print Name Date Date

_____

Signature of patient or Legal Guardian