Last Name _____ **First Name** _____ **MI** ____

Address _____ **Apt** _____

City _____ **State** _____ **Zip** _____

Date of Birth _____/_____/_____ **Age** _____ **Sex** _____ **Social Security#** _____ /_____ /_____

CIRCLE ONE:

Race: White Black Asian Pacific Islander Other Race

Ethnicity: Hispanic Not-Hispanic **Language** _____

Home #_____ **Office #** _____ **Cell #** _____

Email Address _____

Employer's Name _____ **Occupation** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Emergency Contact _____ ***Phone #** _____

Relationship _____

Referred by _____ **Reason for Visit** _____

Insurance Information

Primary Insurance

Subscriber's Name _____

Relationship to Subscriber:

( ) Self ( ) Spouse ( ) Child ( ) Other

Subscriber's Date of Birth _____ /_____ /_____

Subscriber's Social Security # _____-_____-_____

Insurance Company _____

ID # _____

Group # _____ Co Pay _____

Secondary Insurance

Subscriber's Name _____

Relationship to Subscriber:

( ) Self ( ) Spouse ( ) Child ( ) Other

Subscriber's Date of Birth _____ /_____ /_____

Subscriber's Social Security # _____-_____-_____

Insurance Company _____

ID # _____

Group # _____ Co Pay _____

I authorize payment of medical benefits directly to the 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, and vaccines that may apply as directed by my insurance plan. Some insurance plans do NOT cover well visits (physicals). For questions about your coverage, please contact your insurance company directly. If my insurance plan does NOT cover these costs, I agree to pay for the services.

_____ _____

Signature of Patient Date

It is the policy of this office to bill for any missed appointments unless given at least 24 hours notice. I understand that unless I give such notice, I will be charged the rate of a routine office visit.

_____ _____

Signature of Patient Date

Full payment is due at the time of service.
Accepted forms of payment are cash, check, money order or credit card.

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. After your insurance has paid their portion and notified us of you share, the balance will be applied to your credit card. A copy of these charges will be mailed or emailed to you.

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.

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 _____

CARD TYPE: MASTERCARD ____ VISA _____ AMEX _____

CARD NUMBER _____

EXPIRATION DATE: MONTH _____ YEAR _____

SIGNATURE _____ **DATE**_____

_____ *Please check here if you prefer* ***NOT*** *to be notified that your card will be charged for any balances owed. It would be best to leave a credit card on file rather than a debit card.*

Krisczar J. Bungay, MD **Robert L. Cohen, MD**

Stephen M. Dillon, MD **Tom V. Saglimbeni, MD**

Jeffrey J. Kwong, NP

314 W 14th Street, 5th Floor
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

_____
Signature of patient or Legal Guardian

Kriscar J. Bungay, MD **Robert L. Cohen, MD**

Stephen M. Dillon, MD **Tom Saglimbeni, MD**

Jeffrey J. Kwong, NP

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 that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health is used. **HIPAA** provides penalties for covered entities that misuse personal health information.

As required by **HIPAA**, we have prepared this 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 used and disclose your medical records only for each of the following purposes; treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating and managing your health care and related services by one or more healthcare providers. As an example of this would include physical examination.
- **Payment** means such activities as obtaining reimbursements for services, confirming coverage, billing or collection activities 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 by removing all references to individually identifiable information.

We may also contact you to provide appointment reminders or 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 written request to manager David Hathaway, our 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 is 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 you feel that your privacy protections have been violated. You have a right to file 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 to file a complaint contact:

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

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

Gotham Medical Group, LLP

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

Patient MRN/Patient ID in EMR: _____

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

_____ PRINT Name of Patient

_____ Patient Date of Birth

_____ Signature of Patient or Patient's Legal Representative

_____ Date

_____ Print Name of Legal Representative (if applicable)

_____ Relationship of Legal Representative to Patient (if applicable)

Please Fax signed consents to: 917-829-2096

NYULMC HIE, Care Everywhere and Healthix
Fact Sheet

Details about patient information in the NYULMC HIE, Care Everywhere and Healthix and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by the HIE Participants and Care Everywhere Providers only to:
   - Provide you with medical treatment and related services.
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

Unless otherwise permitted by State and Federal law and if permitted by Healthix, your electronic health information shall be disclosed, accessed and used by NYULMC healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare 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.

- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all NYULMC patients and members.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included**. If you give consent, the HIE Participants and Care Everywhere Providers may access ALL of your electronic health information available through the NYULMC HIE and all employees, agents and members of the medical staff of NYU Hospitals Center may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from NYU Hospitals Center or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the NYULMC HIE website **http://health-connect.med.nyu.edu/. You can contact the NYULMC HIE Privacy Officer by writing to: NYU Langone Medical Center, Privacy Officer, One Park Ave, 10th Floor, New York, NY 10016 or calling: 212-263-8488. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.**

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE Participant or Care Everywhere Provider who are involved in your medical care; health care providers who are covering or on call for an approved HIE Participant or Care Everywhere Provider's doctors; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE Participant or Care Everywhere Provider who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **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 one of the HIE Participants or Care Everywhere Providers you have approved to access your records; visit the NYULMC HIE website: http://health-connect.med.nyu.edu/ or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access

to information about you has done so through Healthix, call Healthix at: 877-695-4749; or visit Healthix's website: http://www/healthix.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE Participant or Care Everywhere Provider to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the NYULMC HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The NYULMC HIE, Healthix and persons, including Care Everywhere Providers, who access this information through these health information exchanges must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time the NYULMC HIE ceases operation, or until 50 years after your death, whichever is later.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to NYU Hospitals Center or one of the other HIE Participants, as applicable. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the NYULMC HIE website http://health-connect.med.nyu.edu/. Once completed please fax to 917-829-2085 or submit to your provider.

   Note: Organizations, including Care Everywhere Providers, that access your health information through the NYULMC HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Refusing to Check a Box (make a choice).** Unless you check the "I DENY CONSENT" box, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it.

11. **Risks of Denying Consent**. If you deny consent for HIE Participants and Care Everywhere Providers to access your information through the NYULMC HIE and Healthix, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.