732 Smithtown Bypass suite 200
Smithtown, NY 11787

1690 washington avenue
Bohemia, NY 11716

Tel: 631-656-9040 Fax : 631-656-9030
www.newyorkcmc.com

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Legal last name: | First: | Middle: | Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Preferred name (if different): | Previous legal name(s): | Sex (at birth): ☐ Female ☐ Male

Mailing address: | City: | State: | Zip code: | Date of birth: / / | Social Security number: – –

Physical address (if different from mailing): | City: | State: | Zip code:

Home phone: | Cell phone: | Work phone: | Extension:

Okay to leave voicemail? ☐ Yes ☐ No
If yes, what type of voicemail? ☐ Short ☐ Extended

Okay to send text? ☐ Yes ☐ No
Okay to leave voicemail? ☐ Yes ☐ No
If yes, what type of voicemail? ☐ Short ☐ Extended

Email address (for patients 18 years and older):

Preferred method of contact: ☐ Home ☐ Cell ☐ Work ☐ Text | Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Student Status: ☐ Full-time ☐ Part-time ☐ None | Employment status: ☐ Full-time ☐ Part-time ☐ None | Employer name (if applicable):

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino | Race (please choose <u>one</u> option): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refuse to report

Emergency contact name: | Relationship to patient: | Emergency contact phone:

INSURANCE

Primary insurance carrier: | Primary insurance subscriber ID number:

Primary insurance subscriber's name: | Primary insurance subscriber's date of birth: | Primary insurance subscriber's relationship to patient:

Secondary insurance carrier: | Secondary insurance subscriber ID number:

Secondary insurance subscriber's name: | Secondary insurance subscriber's date of birth: | Secondary insurance subscriber's relationship to patient:

GUARANTOR

Person responsible for bill (guarantor): | Guarantor's date of birth: / / | Address (if different from patient's): | Guarantor's phone number:

Patient's relationship to guarantor: ☐ Self ☐ Spouse ☐ Parent

SHARED CONSENT

With whom may we share your information? Name:	Phone number:	Date of birth:	Relationship:	Health info	Account info
				☐	☐
				☐	☐
				☐	☐

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No Show Policy

I understand that I must cancel appointments within 24 hours of the scheduled appointment time. If I fail to notify the office with an answered phone call, or text message before that time, I agree that you will charge my credit card on file a $25 as a no show/no cancel fee.

In the event I do not show and cancel the appointment accordingly, I hereby authorize you to charge my credit card on file.

Controlled Substance Policy

I understand that this office does not prescribe or dispense any controlled medications under any circumstances.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

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Medical Records Release

(Name of Patient) (Birthdate)

(Street Address) (City, State, Zip Code)

Authorizes:

(Name of Physician)

(Name of Health Care Facility)

(Street Address)

(City, State, Zip Code)

Release of Records to:

(Name of Physician)

(Name of Health Care Facility)

(Street Address)

(City, State, Zip Code)

Information to be Released:

All Clinic Records
Office Notes
Photographs
Visual Fields
X-Ray Reports
Lab Reports
Other (Specify)

For the Following Dates:

Purpose or need for disclosure: (check applicable categories)

Further medical care
Application for insurance
Disability determination
Payment of insurance claim
Vocational rehabilitation evaluation
Other (Specify)
Legal investigation
Personal

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Signature of Patient: ______________________ Date: ______________

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ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have received a copy of New York Comprehensive Medical Care's Notice of Privacy Practices.

Patient Name:_______________________

Signature:__________________________ Date:__________________

****

THIRD PARTY ACCESS FORM

Patient Name: ___________________________________ **Date of Birth:** ____/____/____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING:

Spouse: ______________________________
Family Member: ______________________
Friend: _______________________________
Other: _______________________________

I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected. I understand I may revoke this authorization at any time in writing.

I understand I am under no obligation to sign this authorization. I further understand my ability to obtain treatment will not depend in any way on whether or not I sign this authorization. I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand the clinic named above will not receive compensation for the uses and disclosures I have authorized.

Patient Name:______________________________

Signature_____________________________________ **Date:** __________________

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Patient Responsibility
(Initial each line)

________ **1.** I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

________ **2.** I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

________ **3.** I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

________ **4.** I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

________ **5.** If I am a Medicare patient, I understand that I need to provide the office with both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by New York Comprehensive Medical Care. Further, I authorize New York Comprehensive Medical Care to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by New York Comprehensive Medical Care, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to New York Comprehensive Medical Care for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient Name:________________________________

Signature____ **Date:** __________________

A.P. New York Comprehensive Medical Care

ADALBERT PILIP M.D.
Internal Medicine & Cardiology

732 SMITHTOWN BYPASS
2ND FLOOR - SUITE 200
SMITHTOWN, NY 11787
TEL: (631) 656-9040
FAX: (631) 656-9030

NOTICE OF PRIVACY PRACTICES

Purpose of this notice: To describe how your medical information is used, whom it is disclosed to and how you gain access to it.

A.P New York Comprehensive Medical Care as a healthcare provider is permitted by law to collect, use and disclose your "protected health information" or medical record for the purpose of treatment, payment, internal business operations or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information.

A.P New York Comprehensive Medical Care, PC agrees to abide by the terms of this notice but reserves the right to change the terms at any time. Should we do so, we will notify you in writing.

Use and Disclosure of Protected Health Information (PHI): When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family and the community we take care of. Your physician, office staff and others outside of A.P New York Comprehensive Medical Care i.e. your insurer are allowed access to this information.

Some examples of uses and disclosures of your protected health information are for:

- Treatment by your doctor
- Law enforcement
- Workers compensation
- Appointment reminders
- Payment for your treatment by you or your insurance
- Reporting adverse events of medication or medical devices to the FDA
- Reporting health risks
- Response to legal proceedings
- Organ or tissue donation
- Coroners, funeral directors
- A.P New York Comprehensive Medical Care to determine if we meet the needs of our patients

Any other uses and disclosures not specified require an authorization, including for marketing purposes and disclosures that constitutes the sale of PHI.

Patient Rights:

A. You have the right to inspect and to obtain a copy of your protected health information for as long as the group maintains your record.
*We are permitted by NYS law to charge you a fee of 75 cents per page
B. You have the right to restrict or to limit the use of your protected health information that we use for treatment, payment or operations.
*A.P New York Comprehensive Medical Care reserves the right to deny you treatment should you restrict the use of your protected health Information for treatment, payment or operations, unless the requested restriction relates to disclosures to a health plan and the Protected Health Information relates to a health care service or item which you have paid for in full and out of pocket.
C. You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
D. You have the right to request an accounting of disclosures made of your health information.
*Your request must be submitted in writing, specifying dates and time periods as far back as six years from today, as long as the events in question happened.
E. You have the right to amend your protected health information.
*To amend your health information, your request must be given in writing along with a reason for doing so. Your request can be denied if the information originated outside A.P New York Comprehensive Medical Care.
F. You have the right to request confidential communications as long as it is done in writing
*For example, you can specify that we only contact you at work, at home or by mail, etc.
G. You have the right to receive notifications whenever a breach of your unsecured PHI occurs.

If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to our Compliance Officer.