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

1766 SUNRISE HIGHWAY
BAY SHORE NY, 11706
FAX: (631) 968-2770

Please be advised as of January 1, 2018, this office will no longer be prescribing or dispensing any controlled substances under any circumstances.

We appreciate your cooperation in this matter.

I, ______________________________ acknowledge this office policy.
(Print Name)

Signature: ______________________________ Date: _______________

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## PATIENT REGISTRATION

### PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: (Last, First, MI) | | | |
| Address: | | | |
| City: | State/Province: | Zip: | Country: |
| Mailing Address (if different from above): | | | |
| Home Phone: | Work: | Mobile: | |
| Email: | SSN: | Birth Date: | Sex: M ☐ F ☐ |
| Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐ | | | |
| Race: White ☐ Hispanic ☐ Black/African American ☐ Other Pacific Islander ☐ Other ☐ Asian ☐ Native Hawaiian ☐ American Indian ☐ | | | |
| Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ | | Language: | |
| Contact Preferred: Home ☐ Work ☐ Mobile ☐ | | | |
| Allow Call for Appointment Reminder: Yes ☐ No ☐ | | Leave Message: Yes ☐ No ☐ | |
| Primary Care Physician: | | Referring Physician: | |

### EMPLOYER INFORMATION

| | | | |
|---|---|---|---|
| Employer Name: | | Phone Number: | |
| Address: | | | |
| City: | State/Province: | Zip: | Country: |

### EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Name: | Relationship to Patient: |
| Phone: | Email: |

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## POLICY INFORMATION

| | | | |
|---|---|---|---|
| Patient is Guarantor(Insurer): | Yes ☐ | No ☐ | (if patient is guarantor information is the same as page 1) |
| Guarantor Name: | | Relationship to Patient: | |
| Guarantor Address: | | | |
| City: | State: | Zip: | Country: |
| Guarantor Home Phone: | Work: | Mobile: | |
| Guarantor Birth Date: | Guarantor Sex: M ☐ F ☐ | Guarantor SSN: | |
| Guarantor Employer Name: | | Phone Number: | |
| Guarantor Address: | | | |
| City: | State: | Zip: | Country: |
| **Primary Insurance** | | | |
| Guarantor Name: | | | |
| Policy Number: | Insurance Company Group Name: | | |
| Effective Date: | Expiration Date: | Policy Copay: | |
| Guarantor Name: | | | |
| **Secondary Insurance** | | | |
| Policy Number: | Insurance Company Group Name: | | |
| Effective Date: | Expiration Date: | Policy Copay: | |
| **Tertiary Insurance** | | | |
| Policy Number: | Insurance Company Group Name: | | |
| Effective Date: | Expiration Date: | Policy Copay: | |

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Patient Name: ______________________________ Date: ________________

Address:

______________________________ City/State/Zip ______________________________

Date of Birth: ________________ Phone: ____________________ SSN: ____________

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care
Insurance
Legal Purposes

Military
Personal Use
School ________________

Social Security/Disability
Other: ____________

**I hereby authorize to release my medical records to**

FROM DOCTOR:

______________________________

TO:

______________________________

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical
Operative Reports
Lab/Path Reports

Consultation Report
Discharge/Death Summary Face Sheet
X-Ray Reports/Images

Emergency/Hospital Room Record

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

______________________________
Patient/Guardian Signature

Date__________ Witness's Signature ________________________

NYCMC

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## CLINICAL PRACTICE MANAGEMENT PLAN

*Patient's Name:* ______________________________________________
*Last* *First* *Middle*

## RELEASE OF INFORMATION

*I hereby authorize and direct Dr. Adalbert Pilip, A.P New York Comprehensive Medicare Care, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.*

*X*______________________________________________ ____________________
*Signature of Patient or Authorized Representative* *Date*

## UNIFORM ASSIGNMENT

*I hereby assign, transfer and set over to Dr. Adalbert Pilip, A.P New York Comprehensive Medical Care, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.*

*In addition, I also assign, transfer and set over to all of the other to Dr. Adalbert Pilip, A.P New York Comprehensive from which I may require medical care, sufficient monies and/or benefits to which I may be entitled.*

*X*______________________________________________ ____________________
*Signature of Patient or Authorized Representative* *Date*

*Witness-* ______________________________

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## Acknowledgement of Receipt of A.P New York Comprehensive Medical Care Privacy Practices

I, the undersigned, acknowledge that I have received a copy of A.P New York Comprehensive Medical Care's Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician.

Print Name: ______________________ Date of Birth: ______________

Signature: ______________________ Date: ______________

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## Authorization for the Release of Patient Health Information to a Second Party

I authorize the release of my Patient Health Information to my
*(Fill in name(s) of all that apply.)*

Spouse, ______________________
Family Member, ______________________
Friend, ______________________
School/College Health Services, ______________________
Other, ______________________

By signing below, I acknowledge that this authorization is valid until it is revoked by me.

Patient Signature: ______________________ Date: ______________

Parent/Guardian Signature (if patient a minor): ______________________

Print name of Parent/Guardian: ______________________

NYCMC

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Group #:__________ Name:________________________ MR#:____________ Date:___________

## GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

★ ★ ★ ★ ★ ★ ★ ★

I have read and understand this information. I understand that my insurance company may deny coverage and request that A.P New York Comprehensive Medical Care perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

______________________________ ______________________ ________________
Signature of Patient or Legally Authorized Representative | Print Name | Date

______________________________ ______________________ ________________
Witness | Print Name | Date

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Date: ______________________

Medical Record #: ______________
File#: ______________________

# FINANCIAL AGREEMENT

I/We hereby agree as follows:

1. Guarantee of Payment. Medical care has been or will be provided to the patient whose name appears below. I/We, both jointly and individually, shall be fully responsible for payment of the patient's bill, based on the charges incurred which I/We now agree are fair and reasonable. A.P New York Comprehensive Medical Care may demand full payment of the patient's bill at any time, but the A.P New York Comprehensive Medical Care Practice are not required to do this. Even if New York Comprehensive Medical Care do not demand immediate payment, my/our obligation to make such payment remains the same.

2. When the Patient's Insurance Coverage is Insufficient. If any insurance coverage which the patient may have, such as Blue Shield, Medicare, Medicaid, Compensation or other coverage, rejects the patient's claim or allows only part of the claim, I/we shall be responsible for immediate payment of the balance due to the extent permitted by law.

3. The Agreement. I/We have read and understood this Agreement and have received a copy as well.

______________________
Name of Patient

______________________
Name of Person Guaranteeing Payment

______________________
Signature of Person Guaranteeing Payment

______________________
Home Address

______________________
Telephone Number

______________________
Employer's Name

______________________
Employer's Address

New York Comprehensive Medical Care
732 Smithtown Bypass
2nd Floor Suite 200
Smithtown, NY 11787
(631) 656-9040
Fax – 631-656-9030

______________________

______________________

______________________
Witness

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## 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.*

Date:

Patient Name: ______________________

Date of Birth: ______________________

Chief Complaint: ______________________

Drug Allergies/Sensitivities: ______________________

Emergency Phone #: ______________ Contact Person/Relationship: ______________

| Have you experienced any of following in last 3 years? | Yes | No | Past Medical History | Date |
|---|---|---|---|---|
| Itchy, Stuff and/or runny nose | | | | |
| Itchy, Watery Eys | | | | |
| Itchy Mouth, Lips, Throat or Inner Ear (Circle all that apply) | | | | |
| Frequent Sneezing | | | | |
| Post Nasal Drip (drainage down back of throat) | | | | |
| Joint or Lower Back Pain | | | | |
| Depression/Anxiety/Insomnia (Circle) | | | | |
| Stomach Problems | | | **Current Medication Taking** | **Date** |
| Sinus Pressure | | | | |
| Chronic Fatigue | | | | |
| Fibromyalgia | | | | |
| Frequent Colds and Flus | | | | |
| Hot Flashes/Frequent Perspiring/Night Sweats (circle all that apply) | | | | |
| Shortness of Breath | | | | |
| Seasonal Allergies | | | | |
| Do you currently take over the counter medications? | | | | |

**Family History of**

| Y | N | | Family Member |
|---|---|---|---|
| ☐ | ☐ | Alzheimer's Dz | ________ |
| ☐ | ☐ | Breast Ca | ________ |
| ☐ | ☐ | CAD | ________ |
| ☐ | ☐ | Cerebrovas. Dz | ________ |
| ☐ | ☐ | Cervical Cancer | ________ |
| ☐ | ☐ | Colon CA | ________ |
| ☐ | ☐ | Depression | ________ |
| ☐ | ☐ | DM | ________ |
| ☐ | ☐ | Fe Storage | ________ |
| ☐ | ☐ | Glaucoma | ________ |
| ☐ | ☐ | Hyperchol. | ________ |
| ☐ | ☐ | HTN | ________ |
| ☐ | ☐ | Ovarian CA | ________ |
| ☐ | ☐ | Prostate CA | ________ |
| ☐ | ☐ | Skin CA | ________ |
| ☐ | ☐ | Thyroid Dz | |

**Social History**

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widow(er)

☐ Lives Alone ☐ Separated

Occupation: ______________