Northeast Primary Care

◯ 137 Willis Avenue, Suite 110, Mineola, NY 11501

◯ 235 N Belle Mead Rd, East Setauket, NY 11733

Registration Form

Title (circle one): Mr. Ms. Mrs. Miss Dr. NP PA Other: ____ **Which Lab do you use?** _____

First Name: _____ **M:** _____ **Last Name:** _____

Gender (circle one): Male Female Other **Marital Status (circle one):** Single Married Separated Divorced Widowed Partnered

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Address: _____ **Apt #**_____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ___ ___ ___-___ ___ ___-___ ___ ___ ___ **Cell Phone:** ___ ___ ___ -___ ___ ___ -___ ___ ___ ___

Emergency Contact Name:_____ **Relationship:**_____ **Phone:** ___ ___ ___ -___ __ __ - __ __ __ __ __

Email (print clearly): _____

Work Status (circle one): Employed Unemployed Self-Employed Part-time Student Full-time Student Retired Disabled

Ethnicity: _____ **Religion:** _____

Preferred Language: _____ **Race:** _____

How did you find us? **ZocDoc** **Friend/Relative** **Internet** **Other:** _____

Reason for visit:_____ **Last Physical:** _____

Pharmacy: **Name:** _____ **Phone Number:** __ __ __ -__ __ __-__ __ __ __

Address: _____ **City:** _____ **Zip code:** _____

Primary Insurance: _____ **Name of Policy Holder:** _____

DOB of Policy Holder: __ __/ __ __/ __ __ __ __ **Effective Date:** __ __/ __ __/ __ __

Secondary Insurance: _____ **Name of Policy Holder:** _____

DOB of Policy Holder: __ __/ __ __/ __ __ __ __ **Effective Date:** __ __/ __ __/ __ __

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDARIES OR CARRIERS, OR TO THE PHYSICIAN'S OFFICE OR TO MY ATTORNEY OR OTHER DOCTOR'S OFFICE.
I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO DIGESTICE DISEASE CARE P.C.
I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

SIGNATURE: _____ **DATE:** __ __/ __ __ / __ __ __ __

TURN PAGE

Patient Name: _____

Patient Date of Birth: __ __ / __ __ / __ __ Patient SSN: __ __ __ - __ __ - __ __ __ __

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

NOTICE TO PATIENT:

BY SIGNING THIS FORM, YOU GRANT US CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH CARE INFORMATION FOR THE PURPOSES OF **TREATMENT**, VARIOUS ACTIVITIES ASSOCIATED WITH **PAYMENT** AND **HEALTH CARE OPERATIONS.** OUR **NOTICE OF PRIVACY PRACTICES** PROVIDES MORE DETAILS ON OUR TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS. IF THERE IS NOT A COPY OF THE NOTICE ACCOMPANYING THIS CONSENT FORM, PLEASE ASK FOR ONE. WE ENCOURAGE YOU TO READ IT SINCE IT PROVIDES DETAILS ON HOW INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND DESCRIBES CERTAIN RIGHTS YOU HAVE REGARDING YOUR HEALTH CARE INFORMATION.

AS STATED IN OUR **NOTICE OF PRIVACY PRACTICES,** WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES. IF WE SHOULD DO SO, WE WILL ISSUE A REVISED NOTICE. SINCE REVISIONS MAY APPLY TO YOUR HEALTH CARE INFORMATION, YOU HAVE THE RIGHT TO RECEIVE A COPY BY CONTACTING OUR PRIVACY OFFICER.

YOU HAVE THE RIGHT TO **REVOKE** YOUR CONSENT BY GIVING WRITTEN NOTICE TO OUR PRIVACY OFFICER. THE REVOCATION WILL NOT AFFECT ACTIONS THAT WERE ALREADY TAKEN IN RELIANCE UPON THIS CONSENT. YOU SHOULD ALSO UNDERSTAND THAT IF YOU REVOKE THIS CONSENT, WE MAY DECLINE TO TREAT YOU.

YOU ARE ENTITLED TO A COPY OF THIS **CONSENT FORM A**FTER YOU HAVE SIGNED IT.

I, _____, have read the Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment and health care operations.

_____ **DATE:** _____/ _____ / _____

Patient's Signature or Signature of Patient's Representative

_____ _____

Print Patient's Name or Name of Patient's Representative Relationship to Patient

E-MAIL RELEASE

I, _____ (or Patient's Representative) want to communicate via e-mail with (Northeast Primary Care Physicians PC) on matters related to my health and/or my medical treatment. I understand that any Confidential Health Information I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentially associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted, I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

_____

Print Patient's Name or Name of Patient's Representative

_____ **DATE:** _____/ _____ / _____

Signature of Patient or Patient's Representative

TO BE COMPLETED BY OFFICE

_____ _____

(Witness: Print Name) (Signature of Witness)

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Sejal Sharma Practice Address: 137 Willis Avenue, Suite 110, Mineola, NY 11501 Phone: 516-750-8000 Fax: 516-300-1127

Authorization to Disclose Health Information to Family Members and Friends

Patient Name: _____ DOB: _____ /_____ /_____

I hereby authorize Northeast Primary Care (NEPCP) to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	**Relationship**	**Medical**	**Billing**	**By Phone**	**In Person**

Protected Health Information ("PHI") may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claim status, and third party financing.

I understand that the Health Insurance Portability Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information is set forth on NEPCP'S Notice of Privacy Practices. I understand that any revocation must include by name, address, telephone number, date of this authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer."

I understand that I am not required to sign this Authorization and that NEPCP may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires when I am no longer a patient or have revoked this authorization.

(Check One) I DO _____ DO NOT _____ GIVE PERMISSION to Northeast Primary Care, to leave information on my answering machine and/or with my family members in regards to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of NEPCP. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, NEPCP will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

Signature of Patient of Personal Representative (i.e. Guardian) **Relationship of Personal Representative to Patient**

Date of Authorization _____

No Show/Referral/Deductible Policy

Thank you for trusting your medical care to Northeast Primary Care (NEPCP). When you schedule an appointment with NEPCP, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment. This will allow us enough time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancelation/No Show Policy below:

1. ***No Show*** –
   - ***a.*** Patients who fail to cancel an appointment at least 24 hours prior to that appointment, will be considered a No Show and charged a **$25.00 fee**.
   - ***b.*** No Show Fees are charged to the patient, not the insurance company. These fees are due at the time of the patient's next office visit.
   - ***c.*** As a courtesy to our patients, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, this policy will remain in effect. Not receiving a reminder from our office does not act as a waiver of this fee.
   - ***d.*** We understand that emergencies arise and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show Fee.

2. ***Insurance PCP Selection –***
   - ***a.*** For every insurance plan that requires a Primary Care Physician (PCP) to be selected, a patient must have contacted their insurance company to select their PCP prior to their appointment.
   - ***b.*** It is the patient's responsibility to select a PCP with their insurance company.
   - ***c.*** If a PCP is not selected at the time of the appointment, the patient will be responsible for 100% of the costs associated with that visit.

3. ***In Network Deductible*** – Patients are fully responsible for their in-network deductibles associated with their care.
4.

I have read and understand the Medical Appointment No Show/Referral/Deductible Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) **Relationship to Patient**

_____ _____

Printed Name **Date**