ISLAND MEDICAL CONSULTANTS

11 Ralph Place, Suite 214
Staten Island, New York 10303
Phone: (718) 727-1898 / Fax: (718) 727-8238

PATIENT INFORMATION

Last Name:		**First Name:**		**M.I.**
Home Phone:	**Work Phone:**	**Cell Phone:**	**Referred By:**	
Address:	**City:**	**State:**	**Zip Code:**	
Date of Birth:	**Age:**	**Sex:** M U F	**Primary Language:**	**Marital Status:** S / M / W / D
E-Mail:				

Employer:		**Occupation:**	
Address:	**City:**	**State:**	**Zip:**

INSURANCE INFORMATION

Primary Insurance:	**ID #**	**Group #**	
Subscriber Name:	**Date of Birth:**	**Relationship:**	
Employer:		**Work Address:**	
City:	**State:**	**Zip:**	**Phone Number:**

Secondary Insurance:	**ID #**	**Group #**

PHARMACY

Primary:	**Address and/or Phone Number:**
Secondary:	**Address and/or Phone Number:**
Mail Order:	**Address and/or Phone Number:**

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AUTHORIZATION TO CONTACT

The specific ***TYPE OF INFORMATION*** to be disclosed is limited to emergency situations and rescheduling information. This authorization will remain in effect for one year or until termination of treatment, whichever occurs first.

The specific ***PURPOSE AND NEED*** for such a disclosure would be in the case of an emergency and to reschedule or change an appointment when there have been several unsuccessful attempts to reach the patient.

EMERGENCY CONTACTS

Name:	**Relationship:**
Phone:	

Name:	**Relationship:**
Phone:	

Is there anyone that we *CANNOT SPEAK* with?

Name:
Name:
Name:

HOW CAN WE CONTACT YOU FOR ALL *OTHER* MESSAGES?

***Note:** Appointment confirmations are only done via text message or E-Mail

1. PLEASE CIRCLE ALL THAT APPLY

HOME **CELL** **WORK** **E-MAIL / PORTAL**

2. PLEASE PROVIDE THE INFORMATION FOR THE OPTIONS CIRCLES

Home:	**Cell:**
Work:	**E-Mail:**

I understand and authorize Island Medical Consultants to contact me as stated above.

Print Name: _____ **Date:** _____

Signature: _____

MC
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CONSENT FOR TREATMENT AND AUTHORIZATIONTO BILL INSURANCE

Name: _____ Date of Birth: _____

Please read and initial each item below, then sign at the bottom.

1. _____ I certify that I am requesting the services of Island Medical Consultants for the purposes of evaluations, recommendations and treatment.

2. _____ I certify that I have been advised and have received a copy of my rights to confidentiality. I understand that these rights will be respected and upheld.

3. _____ I understand that Island Medical Consultants does NOT participate in Worker's Compensation or No-Fault / Accident Cases. There will be no documentation of such incidences and the doctors will NOT fill out paper work in connection with such incidents.

4. _____ I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to Island Medical Consultants for any services provided to me. I authorize any holder to release to my insurance company medical information about me to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.

5. _____ I understand that Island Medical Consultants will submit my insurance claims and that I will be responsible for any deductible, co-payments or client fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Island Medical Consultants cannot accept responsibility for collection of my insurance or negotiating a settlement on a disputed claim and I am responsible for payment of my account.

6. _____ I understand that my services and/or treatment with Island Medical Consultants may be terminated in the case of non-compliance. This includes non-adherence to treatment plans and instructions regarding prescribed medications; repeatedly missing appointments; or failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of this practice.

Signature _____ Date: _____

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Appointment Scheduling & Cancellation Policy

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. To do so effectively and efficiently we have developed an appointment system that sets aside ample time for each patient needs and concerns to be addressed.

To reduce the number of "NO-SHOW" and late cancellations, we have implemented an Appointment policy for booking and cancellations; and it is effective immediately.

Our policy is as follows:

1. You MUST make appointments for follow up visits; especially if any form of testing has been ordered for you, a phone call to the office to verify if we received the results is highly recommended.

2. You MUST give our office 24-Hour notice in the event you need to reschedule your appointment. This can be done by calling us at (718) 727-1898 or messaging us via our secure Medent Patient Portal.

3. If you miss an appointment without proper notice we will consider this appointment as a "NO-SHOW" and a $75.00 fee will be assessed to you. This fee will be billed to you directly and is not covered by insurance. The balance must be paid prior to your next appointment. If you do not have a scheduled appointment the balance is expected in a timely fashion and if not will be subject to collections.

4. If you are late for an appointment, our office reserves the right to reschedule the appointment.

5. If you are late for an appointment and the doctor is available to see you, you will be seen as soon as possible. Please remember we schedule an appropriate length of time with each patient, late arrival to your appointment may result in a shortened visit length.

6. Our office makes appointment reminder calls to all patients and can send reminder e-mail and text messages for patients who activate their Medent Patient Portal. It is ultimately the patient's responsibility to ensure they provide the office staff with up to date contact information.

We thank you for trusting Island Medical Consultants with your medical care.

I have read and understand the Appointment Scheduling & Cancellation policy and agree to the terms of this policy.

Print Name: _____ **Date:** _____

Signature: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
ISLAND MEDICAL CONSULTANTS, 11 RALPH PLACE, SUITE 214, STATEN ISLAND, NY 10304

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.