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PATIENT ENCOUNTER FORM

Date _____ **Chart #** _____ **EHR #** _____

Patient's Name _____ **Date of Birth** _____

Preferred Language _____ **Race** _____ **Ethnicity** _____

Gender ☐ **Male** ☐ **Female** ☐ **Other** _____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow/ed**

Home Address _____

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

Home Phone # including area code (_____) _____

Cell Phone # including area code (_____) _____ **EMAIL ADDRESS** _____

Best Phone Number to reach you ☐ Home ☐ Cell ☐ Work

Name of Employer _____ **Work Phone # including area code** (___) _____

Employer 's Address _____

Employer City _____ **State** _____ **Zip Code** _____

** If patient is Married, write spousal information below. If patient is a Minor write Guardian Information below:

Name _____ Phone (___) _____

****

Primary Insurance Company ;Name _____-

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone # (_____) _____ Insured's Name _____

Secondary Insurance Company ;Name _____-

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone # (_____) _____

Worker's Compensation ☐ Yes ☐ No **No Fault** ☐ Yes ☐ No

Contact In Case of Emergency (Other than Spouse): Name _____

Relationship to patient _____ **Contact's Phone #** (____) _____

Referred by (if doctor – provide full name, address, phone #): _____

_____

Reason for Visit:

_____

_____

_____

Patient's Name ____ **Chart #**________ **EHR #** ______________

PATIENT RESPONSIBILITIES

Please be advised that it is the responsibility of the patient to return to this office to obtain their results regarding any testing done in this office and results of tests ordered at an outside facility by this office.

It is conceivable that in any office an abnormal report may be mistakenly placed in a chart without the doctor having seen the report. It is also possible that a consultant's report may be lost in the mail without the doctor knowing that you had seen the specialist or the results of the consultation. It is also very important for you to return to this office when you are advised of a Follow - up visit, so that there is continuity of your medical care.

It is the patient's responsibility to return to this office, in order to avoid these problems. Patients are strongly advised to return to the office for all follow-ups to ensure that all problems are addressed in a timely and proper manner. You, the patient must also share in the responsibility of maintaining your health care.

We appreciate your cooperation and ask that you sign below indicating your understanding of our office policy.

ASSIGNMENT OF BENEFITS

I authorize the above-named party to release medical information necessary for the processing of my Medical claims.

Signature ______________________________ ***Date*** ____________ ***Print Name:*** ______________________________

I assign payment of benefits to the above-named party.

Signature ______________________________ ***Date*** ____________ ***Print Name:*** ______________________________

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient's Name: ____ **Date of Birth:** ______________

I understand that, under The Health Insurance Portability Accountability Act of 1996, I have certain rights to privacy in regard to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices.

The practice reserves the right to change the terms of its Notice of Privacy Practices. I understand the Practice will provide current Notice of Privacy Practices on request.

Signature/Relationship: ____________________________________ Date: ___________________

**Office Use Only **

I was unable to obtain the patient's signature.

Employee's Name: ____ Date: __________________

Reason: ____

PHARMACY INFORMATION

Pharmacy Name: ____

Address/City/Zip ____

Phone # (______) ___________________________ Fax # (______) ___________________________

CANCELLATION POLICY

CO-PAYMENT, CO-INSURANCE, APPOINTMENTS AND CANCELLATION POLICIES

CO-PAYMENT POLICY

All co-payments are due at time of office visit, including all testing co-payments required by your insurance plan. If you have a deductible, that payment is also due in full at time of visit.

APPOINTMENTS AND CANCELLATION POLICY

We strive to provide quality medical care in a timely manner. This not only requires patients making appointments, but also notifying this office in advance if you need to cancel your appointment. This will help us better meet the medical needs of our patients, including someone in need of urgent treatment.

If you do need to cancel your appointment, we require advance notice of 24-hour notice…Tuesday for a Thursday appointment and Saturday morning for a Monday appointment. Remember, appointments are in high demand and notifying us of your cancellation will enable another patient the possibility to be seen by the doctor. **Please call (718) 592-3200 to cancel your appointment.**

LATE CANCELLATIONS ARE CONSIDERED A "NO SHOW"

A "NO SHOW" is a patient who missed their appointment without calling to cancel 1 working day in advance.

A failure to present yourself at the time of your scheduled appointment will be recorded in your chart as a "NO SHOW". This is subject to an administrative fee of $25 per day (a total $75).

I, ____ have read and am aware of the above stated policies.

Print patient's full name

____ ____________

Patient's Name _____ **Chart #**_____ **EHR #** _____

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

INTRODUCTION:

Audrey M. Weissman, M.D. understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information" (PHI). "PHI" includes any individually identifiable information that we obtain from you or others that relate to your past or future physical or mental health, the health care you received, or payment for your health care.

As required by law, this notice provides you with the information about your rights and our legal duties and privacy practices with respect to the privacy of "PHI". This notice also discusses the uses and disclosures we will make of your "PHI". We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time, as required by Federal and State Laws including but not limited to the HIPAA Omnibus Rule and to make the revised notice effective for all "PHI" we maintain. Any revised copy of this "PHI" will be available upon request, in our office, and on our website.

PATIENT RIGHTS:

You have a right to obtain a copy of your paper or electronic medical record.
You have the right to request a correction to your paper or electronic medical record. We may say "no" to your request, but we'll tell you why in writing within 60 days. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee as allowed by law.
You may request confidential communication and ask us to limit the information we share. You have a right to get a list of those with whom we've shared your information. You have the right to file a complaint if you believe your privacy rights have been violated: U.S. Department of Health and Human Services Office for Civil Rights 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-877-696-6775 or visiting: www.hhs.gov/ocr/privacy/complaints/.

PATIENT'S CHOICES:

You have some choices in the way that we use and share information as we: Tell family and friends about your condition; provide disaster relief; provide mental health care; market our services and sell your information.

_____: You may fax my information to (___) _____ _____: You may mail results to my home
_____: You may leave a voice message on my answering machine or cell phone _____: Speak to the following family member(s) regarding my medical information

PERMITTED USES AND DISCLOSURES:

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of use and disclosure, we have provided a description and an example below. However, not every particular use of disclosure in every category will be listed.

TREATMENT means the provisions, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

PAYMENT means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determination of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third-Party Payer about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third-Party Payer for the services rendered to you, we can provide the Third-Party Payer with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release for you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law. If you paid for services-out-of-pocket, we must accommodate any request you provide that we do not disclose your PHI related solely to those services paid for out-of-pocket if the disclosure is to be made to a health plan for payment or health care operations.

HEALTH CARE OPERATONS means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician review, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your "PHI" to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your "PHI" in the following ways:

We may share your health information for certain situations such as:
Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety; We can use or share your information for health research; Comply with state or federal laws as required; In response to organ and tissue donations requests: Share health information about you with organ procurement organizations; For worker's compensation claims;
For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services; In response to a court or administrative order, or in response to a subpoena.

I, _____ acknowledge that I have been provided a copy of Audrey M. Weissman, M.D.'s Privacy Notice.
Print Patient's Full Name

Patient's Signature: _____ Date _____

Patient is ☐ unable to or ☐ refuses to sign this acknowledgement. This acknowledgement form will be retained in your record for six (6) years as required by federal law.

Privacy Official: Audrey Weissman Phone # (718) 592-3200 e-mail address audrey@regoparkmed.com