MANHATTAN QUEENS PEDIATRICS

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PATIENT'S REGISTRATION FORM

PATIENT'S INFO

(Last Name)_____ **(First Name)** _____ **(Middle)** ____

Date of Birth: _____/_____/_____ **(Male)** _____ **(Female)** _____

Address: (Street) _____ **(Apt#)** _____

(City)_____ **(State)** _____ **(Zip)** _____

Home Phone #: (____**)** _____-_____ **Other #: (**____**)** _____-_____

PARENT(S)/GUARDIAN(S) INFO

Parent #1: (Last Name)_____ **(First Name)** _____

Date of Birth: _____/_____/_____ **SS#** _____-_____-_____ **Relationship:**_____

Address: (Street) _____ **(Apt#)** _____

(City)_____ **(State)** _____ **(Zip)** _____

Cell Phone #: (____**)** _____-_____ **Work/Other #: (**____**)** _____-_____

Parent # 2: (Last Name)_____ **(First Name)** _____

Date of Birth: _____/_____/_____ **SS#** _____-_____-_____ **Relationship:**_____

Address: (Street) _____ **(Apt#)** _____

(City)_____ **(State)** _____ **(Zip)** _____

Cell Phone #: (____**)** _____-_____ **Work/Other #: (**____**)** _____-_____

INSURANCE INFORMATION

Primary: Policy Holder (Insured): Mother: _____ Father: _____ Patient (CHP)_____

Policy #/ID: _____**Grp#**_____

Effective date: _____/_____/_____ **Co-Payment: $**_____**.**_____

Insurance Co. _____

Street/P.O. Box: _____

Phone #: (_____**)** _____-_____

Employer Name: _____ **Phone #: (**____**)** _____-_____

Address: _____

ASSIGNMENT OF BENEFITS: I hereby assign to Manhattan Queens Pediatrics all benefits to which I may be entitled as an insured party on behalf of my child. These benefits may be from a government agency, Insurance carrier or others who are financially liable for the care or treatment rendered to my dependent(s).

RELEASE OF INFORMATION: I hereby authorize and direct Manhattan Queens Pediatrics to release all information needed to substantiate payment or medical care to government agencies, insurance carriers, or others who are financially liable or medically liable for my child's hospitalization and/or medical care.

PARENT or GUARDIAN SIGNATURE _____ DATE: _____/_____/_____

Manhattan Queens Pediatrics

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

Patient MRN/Patient ID:

Please Fax signed consents to: **917-829-2096**

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please ☑ Check

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

_____ _____
PRINT Name of Patient | Patient Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative | Date

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)

NYULMC HIE, Care Everywhere and Healthix
Fact Sheet

Details about patient information in the NYULMC HIE, Care Everywhere and Healthix and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by the HIE Participants and Care Everywhere Providers only to:
   - Provide you with medical treatment and related services.
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

Unless otherwise permitted by State and Federal law and if permitted by Healthix, your electronic health information shall be disclosed, accessed and used by NYULMC healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all NYULMC patients and members.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included**. If you give consent, the HIE Participants and Care Everywhere Providers may access ALL of your electronic health information available through the NYULMC HIE and all employees, agents and members of the medical staff of NYU Hospitals Center may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from NYU Hospitals Center or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the NYULMC HIE website **http://health-connect.med.nyu.edu/. You can contact the NYULMC HIE Privacy Officer by writing to: NYU Langone Medical Center, Privacy Officer, One Park Ave, 10th Floor, New York, NY 10016 or calling: 212-263-8488. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.**

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE Participant or Care Everywhere Provider who are involved in your medical care; health care providers who are covering or on call for an approved HIE Participant or Care Everywhere Provider's doctors; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE Participant or Care Everywhere Provider who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call one of the HIE Participants or Care Everywhere Providers you have approved to access your records; visit the NYULMC HIE website: http://health-connect.med.nyu.edu/ or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access

to information about you has done so through Healthix, call Healthix at: 877-695-4749; or visit Healthix's website: http://www/healthix.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE Participant or Care Everywhere Provider to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the NYULMC HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The NYULMC HIE, Healthix and persons, including Care Everywhere Providers, who access this information through these health information exchanges must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time the NYULMC HIE ceases operation, or until 50 years after your death, whichever is later.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to NYU Hospitals Center or one of the other HIE Participants, as applicable. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the NYULMC HIE website http://health-connect.med.nyu.edu/. Once completed please fax to 917-829-2085 or submit to your provider.

   Note: Organizations, including Care Everywhere Providers, that access your health information through the NYULMC HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Refusing to Check a Box (make a choice).** Unless you check the "I DENY CONSENT" box, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

11. **Risks of Denying Consent**. If you deny consent for HIE Participants and Care Everywhere Providers to access your information through the NYULMC HIE and Healthix, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.

Rahul Hate, M.D., F.A.A.P.
Blair Guidera, M.D., F.A.A.P.
Margot Martino, M.D., F.A.A.P.

PEDIATRICS

155 East 38th Street
New York, NY 10016
Phone: (212) 490-2446
Fax (212) 599-2376

70-53 Broadway
Jackson Heights, NY 11372
Phone: (718) 426-6655
Fax: (718) 457-0183

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Conduct e-mail inquires to you once you have provided your email to our registration form as permission for usage.

I have received, and read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the addresses above to obtain a current copy of the Notice of private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do disagree then you are bound to abide by such restrictions.

PATIENT'S NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I attempted to obtain the parent/guardian's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Elias R. Halac, M.D., F.A.A.P.
Rahul Hate, M.D., F.A.A.P.
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CREDIT CARD AUTHORIZATION

We accept all major credit and debit cards.

We have decided to require credit card information for each patient. This information is a part of your confidential medical chart.

WHY DO WE NEED THIS INFORMATION?

- Many plans now subtract deductibles, co-payments and coinsurances from this negotiated fee that you are responsible for each year, per your insurance provider.
- We have no way of knowing exactly what these deductibles, co-payments and coinsurances fully are until payment is received from your plan.
- Dependant(s) processing is the responsibility of the policy holder and must be completed on time. Also your carrier will not pay if you do not register your dependant(s) in time allowed. You are responsible to cover these charges.

The information provided will ONLY be used for the above charges when we receive the explanation of benefits from the insurance carrier and our statement has been generated. If we **DO NOT** receive payment within **30 business days** from the statement date we will process payment via your credit card.

If you elect to decline our request for credit card information and we must bill you, a $25.00 fee will be charged to the patient's account

** FORM MUST BE COMPLETED BY PARENT/GUARDIAN ONLY **
** PLEASE PRINT CLEAR **

Cardholder's Name: _____

Cardholder's Address: _____

Cardholder's Home #: _____ Work#: _____ Cell#: _____

Type of Card given authorization for: ____VISA ____MasterCard ____DISCOVER ____AMEX

Credit Card #: _____ Expiration Date: _,_____

ALL PATIENTS COVERED BY THIS AGREEMENT (Last name, First name)

1. _____ D.O.B _____/_____/_____
2. _____ D.O.B _____/_____/_____
3. _____ D.O.B _____/_____/_____
4. _____ D.O.B _____/_____/_____
5. _____ D.O.B _____/_____/_____

_____ _____
Cardholder's Signature Date

YOU WILL BE ASKED TO COMPLETE THIS FORM AGAIN ONCE THE CURRENT CARD ON FILE EXPIRES