



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 <input type="checkbox"/> F <input type="checkbox"/>
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/>			
Race: White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian <input type="checkbox"/>			
Ethnicity: Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/>			Language:
Contact Preferred: Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile <input type="checkbox"/>			Leave Message: Yes <input type="checkbox"/> No <input type="checkbox"/>
Allow Appointment Reminder: If Yes, please choose one method Call <input type="checkbox"/> Text <input type="checkbox"/> No <input type="checkbox"/>			
Primary Care Physician:		Referring Physician:	
Pharmacy Name/Address/Phone:			

EMPLOYER INFORMATION

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

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:
Phone:	Email:

POLICY INFORMATION

Patient is the Insured:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(if no complete the Insured fields below)	
Insured Name:		Relationship to Patient:		
Insured Address:				
City:		State:	Zip:	Country:
Insured Home Phone:		Work:		Mobile:
Insured Birth Date:		Insured Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Insured SSN:
Insured Employer Name:			Insured Employer Phone Number:	
Insured Employer Address:				
City:		State:	Zip:	Country:
Primary Insurance				
Policy Number:		Insurance Company Group Name:		
Effective Date:		Expiration Date:		Policy Copay:
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:

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.

Stony Brook Community Medical 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.

Stony Brook Community Medical, 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 Stony Brook Community Medical 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
- Stony Brook Community Medical 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.
*Stony Brook Community Medical 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 after April 12, 2003.
- 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 Stony Brook Community Medical, PC.
- 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.

Acknowledgement of Receipt of
Stony Brook Community Medical's Privacy Practices

I, the undersigned, acknowledge that I have received a copy of Stony Brook Community Medical's Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's *Compliance Officer*.

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

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, _____ Ph: _____

Family Member, _____ Ph: _____

Friend, _____ Ph: _____

School/College Health Services, _____ Ph: _____

Other, _____ Ph: _____

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: _____

All Inclusive Primary Care

300 East Main Street, Suite 6 Smithtown, NY 11787 Phone (631) 257-5290 Fax (631) 257-5295

New Patient Medical History

Name: _____ Date of Birth: ____/____/____ Age: ____ Sex: ____
How did you hear about our practice? _____

Please briefly state in the box below the reason for your visit

Past Medical History

Condition /Disease	Year Began	Condition /Disease	Year Began
<input type="checkbox"/> Hypertension		Other(s):	
<input type="checkbox"/> High Cholesterol			
<input type="checkbox"/> Hyper/Hypothyroidism			
<input type="checkbox"/> COPD, Emphysema or Asthma			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> GERD			
<input type="checkbox"/> Depression or Anxiety			
<input type="checkbox"/> Heart Conditions			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

<u>Operation / Hospitalization / Injury</u>	<u>Month/ Yr</u>	<u>Operation / Hospitalization / Injury</u>	<u>Month /Yr</u>

Other Physicians and Specialists

List below your other physicians (i.e. Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

Medication/Food Allergies or Intolerances

<i>Medication //Food</i>	<i>Reaction</i>	<i>Medication //Food</i>	<i>Reaction</i>

Family Health History

[illegible]

Health Maintenance				
Test Performed	Date			
Lipid (Cholesterol)		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Colonoscopy		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mammography		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pap Smear		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bone Density		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dental Exam				
Eye Exam				

Vaccinations	
	Date
Tetanus (Tdap)	
Influenza	
Pneumovax (Pneumonia)	
Zostavax (Shingles)	

Current Medications			
Medication	Dosage	Medication	Dosage

Social, Educational and Work History	
Marital Status:	
Work Status (circle one): Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/>	Hours worked per week:
Do you drink alcohol?	Number of drinks per week?
Are you a smoker?	If yes, how many packs per day?
Are you a former smoker?	If yes, what year did you quit?
Do you exercise?	Duration and Frequency?
Over the past two weeks, how often have you been bothered by the following _problems:	
Little interest or pleasure in doing things? <input type="checkbox"/> Not at all <input type="checkbox"/> Some days <input type="checkbox"/> More days than not <input type="checkbox"/> Nearly every day	
Feeling down, depressed, or hopeless? <input type="checkbox"/> Not at all <input type="checkbox"/> Some days <input type="checkbox"/> More days than not <input type="checkbox"/> Nearly every day	

Review of Systems

Please mark any **persistent** symptoms you have had in the **past few months**. Read through every section and mark "no problems" if none of the symptoms apply to you.

General

- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness

☐ Fever/chills

☐ **No problems**

Skin

- ☐ New or change in mole
- ☐ Rash/itching

☐ **No problems**

Breast

- ☐ Breast pain/lump/nipple discharge

☐ **No problems**

Ears/Nose/Throat

- ☐ Nosebleeds

☐ Trouble swallowing

☐ Frequent sore throat,

hoarseness

- ☐ Hearing loss/ringing in ears

☐ **No problems**

Eyes

- ☐ Change in vision

☐ Eye pain

☐ Eye redness

☐ **No problems**

Cardiovascular

- ☐ Chest pain/discomfort

☐ Palpitations (fast or irregular heartbeat)

☐ **No problems**

Respiratory

- ☐ Cough/Wheeze

☐ Loud snoring/altered

breathing during sleep

- ☐ Short of breath with exertion

☐ **No problems**

Gastrointestinal

- ☐ Heartburn/reflux/indigestion

☐ Blood or change in bowel movement

☐ Constipation

☐ **No problems**

Genitourinary

- ☐ Leaking urine

☐ Blood in urine

☐ Nighttime urination or increased frequency

☐ Discharge from penis or vagina

☐ Concern with sexual function

☐ **No problems**

Musculoskeletal

- ☐ Neck pain

☐ Back pain

☐ Muscle/joint pain

☐ **No problems**

Endocrine

- ☐ Heat or cold sensitivity

☐ **No problems**

Hematologic/Lymphatic

- ☐ Swollen glands

☐ Easy bruising

☐ **No**

problems

Neurological

- ☐ Headache

☐ Memory Loss

☐ Fainting

☐ Dizziness

☐ Numbness/tingling

☐ Unsteady gait

☐ Frequent falls

☐ **No problems**

Allergic/Immune

- ☐ Hay fever/allergies

☐ Frequent infections

☐ **No problems**

Psychiatric

- ☐ Anxiety/stress/irritability

☐ Sleep problems

☐ Lack of concentration.

☐ **No problems**

Women only

- ☐ Pre-menstrual symptoms (bloating, cramps, irritability)

☐ Problem with menstrual periods

☐ Hot flashes/night sweats

☐ **No problems**

Please list any other concerns here: _____

ALL INCLUSIVE PRIMARY CARE

Patient Portal

Patient's First Name: _____

Patient's Last Name: _____

Patient's Date of Birth: _____

Patient's Email Address: _____

Security Question:

Patient's Postal-Zip Code: _____

Prescription Refill Policy

Effective 12/10/18

Currently our practice has had an increase in the amount of calls requesting medication refills. In an effort to provide quality care in an efficient manner, and safely manage refill requests, it has become necessary for our practice to implement a new prescription refill policy. While we understand this change will affect you, we hope by keeping you informed of the policy change, to continue to work together to ensure high quality and safe medical care.

1. Prior to your next visit you should review your medications and determine which if any you will need refilled. If you have questions regarding medications, you should discuss them at your appointment.
2. It is **your responsibility** to notify AIPC in a timely manner when refills are necessary. **Don't wait until you run out of medication.** Refill requests may take up to 48hrs to be processed. If you use mail order pharmacy you should give 2 weeks' notice before medication will run out.
3. All refill requests will be handled during business hours Monday-Friday. No medications will be refilled on Saturday, Sunday or Holidays.
4. Refills will only be provided for medications prescribed by AIPC providers.
5. You are required to be compliant with your follow up visits in order to have the medication refilled.
6. If you are requesting a refill and require lab work or a follow up visit, your provider may call in a limited amount of medication until you come in or have the necessary testing. **This is not to exceed one weeks' time of medication.**
7. It is your responsibility to schedule your appointments prior to leaving after your visit, and/or prior to the prescription running out.
8. If you are requesting a controlled substance you must be compliant with your follow up care.
9. It is **your** responsibility to inform the staff of the prescription name, strength, dosage, and correct pharmacy information.
10. Some medications require pre-authorization, this may take several days. Please note AIPC will process these requests as quickly as possible. We will inform you once approval has been obtained.
11. New symptoms or problems require an appointment.

Acknowledgement of Policy:

Print Patient Name: _____ Patient Signature: _____

Date: _____

Signature if other than Patient: _____ Relationship: _____

Date: _____



AD2N538



AGREEMENTS FOR PHYSICIAN PRACTICES

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Financial Agreement/Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital/University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits. I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital/professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

I understand that if I have any questions about my bills I may call:

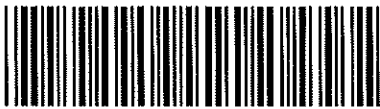
- 631-444-4151 for Patient Accounts/Hospital Billing
- 631-444-4800 for CPMP Physicians Billing

Release of Information: I consent to the release of all or part of my health record, including my Social Security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital/University Faculty Practice Corporations to obtain reimbursement for my care. I also understand that my Social Security number may be provided to the New York Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

Release of Information to Primary Care Provider & Uniform Assignment

Release of Information to Primary Care Provider: I authorize Stony Brook University Hospital, and University Faculty Practice Corporations staff to disclose health care-related information to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital/University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.



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AGREEMENTS FOR PHYSICIAN PRACTICES

The following section **ONLY** pertains to Medicare patients.
Patients signing this form who have Medicare Benefits understand that this
information is included for their signature.

MEDICARE

Medicare Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to the physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.



AGREEMENTS FOR PHYSICIAN PRACTICES

Privacy Acknowledgement

Privacy Acknowledgement: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV-related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

I have read this entire document and I understand it. I have been given the chance to ask questions and I understand that I may ask more questions at any time.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X

Signature of Patient (or representative)

Relationship (if other than Patient)

Time

Date

Print Name of Witness

Title or Relationship to Patient

X

Signature of Witness

Time

Date

**My Signature indicates approval related to my care and treatment by the University
Faculty Practice Corporations (UFPCs) listed:**

Stony Brook Anaesthesiology, UFPC
Stony Brook Children's Service, UFPC
Stony Brook Dermatology Associates, UFPC
Stony Brook Emergency Physicians, UFPC
Stony Brook Family and Preventive Medicine, UFPC
Stony Brook Internists, UFPC
Neurology Associates of Stony Brook, UFPC
New York Spine & Brain Surgery, UFPC
University Associates in Obstetrics & Gynecology, UFPC

Stony Brook Ophthalmology, UFPC
Stony Brook Orthopaedic Associates, UFPC
Stony Brook Pathologists, UFPC
Stony Brook Psychiatric Associates, UFPC
Stony Brook Radiation Oncology, UFPC
Stony Brook Radiology, UFPC
Stony Brook Surgical Associates, UFPC
Stony Brook Urology, UFPC



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AGREEMENTS FOR PHYSICIAN PRACTICES

Documentation of Interpreter or Special Assistance

An interpreter or special assistance was used to obtain consent from this patient as follows:

- ☐ Foreign Language (*specify*) _____
- ☐ Sign Language
- ☐ Visually Impaired
- ☐ Other (*specify*) _____

Interpretation or special assistance provided by _____
(*Fill in name of interpreter and title or relationship to patient*)

X _____
Signature of Witness Time Date

Verbal Consent

When verbal consent is given, whether by telephone or in person, the person giving consent/agreement/acknowledgement or refusal clearly states their name, date of birth and relationship to the patient. This is documented clearly on the general consent and agreements form.

I _____, verify my name as stated. My address is _____
(*Name*) (*Street Address*) (*City, Village, Hamlet*)

My phone number is _____, my date of birth is _____, and my relationship to
the patient is _____

Further, all verbal consent, whether by telephone or in person is witnessed by two staff members working at any of the campus locations of Stony Brook Hospital.

_____ X _____
Print Name of Witness 1 Signature of Witness 1 Time Date

_____ X _____
Print Name of Witness 2 Signature of Witness 2 Time Date



PP2C697

GENERAL CONSENT FOR TREATMENT FOR AMBULATORY PRACTICES

My signature below indicates my agreement and understanding of:

1. **General Consent for Treatment:** I consent for _____
(practice name)
and its staff, physicians and other practitioners (collectively, the “Practice”) to provide and perform such medical care, tests, procedures and other services that are needed or helpful by the Practice for my health and well-being. I understand that this consent will be in effect for one year.
2. **Telehealth Services:** I understand that I may elect to receive certain services via Telehealth and I should inform my practitioner if I am interested in this option.
3. **Responsibility for Patient Care:** I understand that a practitioner is responsible for my care and that he/she may assign doctors, practitioners and staff as deemed appropriate to provide care to me. I also understand that, since the Practice is a teaching site, medical, nursing, social work and other students may observe or assist in my care under the direction of my practitioner and other staff members.
4. **Photographs/Video/Voice Recordings:** I understand that photographs, video and/or voice recordings (the “Recordings”) may be taken of me and used for medical purposes such as documenting or planning my care or for quality assurance or education purposes. I understand that the photographs, videos and/or voice recordings taken to document my care are part of my medical record and those taken for other purposes are not part of my medical records. To the extent that such Recordings identify me, I understand that they shall receive the same confidentiality protections as my other health information.

I have carefully read and fully understand this consent form and have had all my questions answered.

Patient's Signature: X **Date:** _____