

PATIENT REGISTRATION

PATIENT INFORMATION

Name: (Last, First, MI)						
Address:						
City:	State/Province	ce:	Zip: Country:			
Mailing Address (if different from above)):					
Home Phone: Work:			Mobile:		le:	
Email:	SSN:		Birth Date:		Sex: M □ F □	
Race: White Hispanic	:□ Bla	ack/African Am	erican 🗆	n □ Other Pacific Islander □		
Other Asian	Na	ntive Hawaiian	□ American Indian □			
Ethnicity: Hispanic/Latino	Not Hispanic,	/Latino □	Other Preferred Language for communication:			
Contact Preferred: Home □ Work □ Mobile □						
Allow Appointment Reminder: If Yes, please choose one method Call Text No Leave Message: Yes No No Leave Message: Yes No No No No No No No N					Leave Message: Yes □ No □	
Primary Care Physician:			Referring Physician:			
If parents are divorced or separated please fill out this section:						
Who has custody?						
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child						
or from obtaining information about the child's medical treatment? \square Yes \square No If yes, please explain and provide a copy of any legal paperwork that supports this restriction.						
EMERGENCY CONTACT INFORMATION						
Name:		Relationship to Patient:				
Phone:		Email:				

CONTACT/POLICY INFORMATION

Parent 1 Name:		Relationsh	ip to Patien		nsurance Policy Yes No (Holder circle one)	
Parent 1 Address:					100	chiefe offer	
City:	State:		Zip:		Country:		
Home Phone:		Work:		M	Mobile:		
Birth Date:	Sex: M □ F □ SSN:		N:				
Employer Name:		Phone N		Phone Numb	lumber:		
Address:				<u>l</u>			
City:	State:	te: Zip:			Country:		
Parent 2 Name:	Relations		nip to Patient:		Insurance Policy Holder Yes No (circle one)		
Parent 2 Address: (if different than above)							
City:	State:		Zip:		Country:		
Home Phone:		Work:		M	obile:		
Birth Date:	Sex: M □	F□		SSN	N :		
Employer Name:				Phone Numb	ber:		
Address:							
City:	State:		Zip:		Country:		
Primary Insurance			Policy Hol	der			
Policy Number:	Insurance Company Group Name:						
Effective Date:	Expiration Date:				Policy Copay:		
Secondary Insurance	ance		Policy Holder				
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.

<u>Use and Disclosure of Protected Health Information (PHI)</u>: 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.
- 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.
- . 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 Patien	t Health Information to a Second Party
I authorize the release of my Pa (Fill in name(s) o	•
Spouse,	Ph:
Family Member,	
Friend,	
School/College Health Services,	
Other,	
By signing below, I acknowledge that this authoriz	zation is valid until it is revoked by me.
Patient Signature:	Date:
Parent/Guardian Signature (if patient a minor):	
Print name of Parent/Guardian:	

Group #	: Patient Name:		MR#:	Date:	
	<u>CLINICAI</u>	L PRACTICE N	MANAGEMEN	T PLAN	
Patient's Name:	Last	First		Middle	
	<u>R</u>]	ELEASE OF IN	NFORMATION		
to release to gov information need	vernmental agencies, insurance	ce carriers, or other or such medical car	rs who are financia	etice Corporations having treate ally liable for my medical car resentatives thereof to examin	e, all
XSignature of Pa	tient or Authorized Represent	ative		Date	
		UNIFORM AS	SIGNMENT		
monies and/or be		tled from governme	ental agencies, insu	ity Faculty Practice Corporation rance carriers, or others who a for my dependent.	
medical care, suf are as follows: S Internists, New Gynecology, Story Story Brook Chil	ficient monies and/or benefits stony Brook Anaesthesiology York Spine and Brain Surger ny Brook Preventative Medic	to which I may be, Stony Brook Derry, Neurology Associane Services, Stony Psychiatric Associa	entitled. These oth matology, Stony E ciates of Stony Bro Brook Ophthalmo	ctice Corporations from which her University Faculty Practice Brook Family Medical Group, ok, University Associates of C logy, Stony Brook Orthopaedic adiation Oncology, Stony Brook	Corporations Stony Brook Obstetrics and a Associates.,
XSignature of Pa	tient or Authorized Represent	ative		Date	
	A	ccount Representati	ve:		

PA 6a (4/13-eb)

Group #:	Name:		MR	#:	
Date:	-				
	St	ony Brook Childi P.O. Box Stony Brook, N	1559		
		GUARANTEE OF	PAYMENT		
Many insurance authorization for transcessary authorization have not received responsible for all be responsible for your insurance plasses medically necessary	eatment and for rations from you prior approval charges if your all deductibles an, and any se	llow-up visits. It in insurance comp for the service or insurance compains co-insurance, co	is your responsite any prior to rece authorization hand does not agreen payments, any s	bility as a pa eiving medica as been den ee to pay. In service that	atient to obtain all al services. If you nied, you are fully addition, you will is not covered by
* *	*	* *	*	*	*
I have read and ur coverage and requ agree to be person above is relying on service based on s	est that Stony E nally and fully re nthis promise a	brook Children's S sponsible for all c	ervices perform t charges. I unders	this medical s stand that th	service anyway. I e provider named
Signature of Pation Legally Authori Representation	zed	Print Naı	me		Date
Witness		 Print Nar	 me		 Date

MCGOP 3/14