



STONY BROOK INTERNISTS

NORTH SUFFOLK CARDIOLOGY

DAVID M. BENSON, M.D., FHRS
 PETER F. BRUNO, JR., M.D., FACC
 CHRISTOPHER M. CESA, M.D.
 EMANUEL D. CHRYSOS, M.D.
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 1741-A NORTH OCEAN AVENUE, MEDFORD, NY 11763 (631) 941-2000 FAX (631) 941-2009
 745 ROUTE 25-A, SUITE F, ROCKY POINT, NY 11778-9552 (631) 941-2000 FAX (631) 941-2008
 ST. CATHERINE'S MEDICAL ARTS BUILDING • 48 ROUTE 25-A, SUITE 108, SMITHTOWN, NY 11787-1447 (631) 941-2000 FAX (631) 686-2309

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"/>		
Allow Call for Appointment Reminder:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Leave Message:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary Care Physician:	Referring Physician:		

EMPLOYER INFORMATION

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

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:
Phone:	Email:



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POLICY INFORMATION

Form with fields for Patient is Guarantor, Guarantor Name, Address, City, State, Zip, Country, Phone, Birth Date, Sex, SSN, Employer Name, Primary Insurance, Secondary Insurance, Tertiary Insurance.



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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:

- 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
- 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.
- You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
- 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.
- 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.



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**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, _____

Family Member, _____

Friend, _____

School/College Health Services, _____

Other, _____

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: _____