Northwell Health™
Physician Partners

DONALD AND BARBARA ZUCKER SCHOOL of MEDICINE AT HOFSTRA/NORTHWELL

# PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: ____/____/____ Sex: _____

Marital Status: _____ E-mail: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Employer: _____ Cell Phone: ( ) _____

| Race: | American Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Pacific Islander | White |
|---|---|---|---|---|---|

Ethnicity: Hispanic/Latino Not Hispanic/Latino Primary language: _____

## INSURANCE INFORMATION

Primary Insurance: _____ Phone #: ( ) _____

Policy/ID#: _____ Group #: _____

Insured/Card Holder's Name: _____

Insured's Date of Birth: ____/____/____ Relationship to patient: _____

Secondary Insurance: _____ Phone #: ( ) _____

Policy/ID#: _____ Group #: _____

Insured/Card Holder's Name: _____

Insured's Date of Birth: ____/____/____ Relationship to patient: _____

## EMERGENCY CONTACT

Last name: _____ First Name: _____ Relationship: _____

Home Phone: ( ) _____ Work: ( ) _____ Cell Phone: ( ) _____

PHARMACY NAME: _____ Phone #: ( ) _____

Address: _____

**FINANCIAL RESPONSIBILITY:** I acknowledge full financial responsibility for services rendered by Benjamin M. Schwartz, MD, Anze Urh, MD or clinicians providing medical coverage on their behalf. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles or copayments. I understand payment of copayments is expected at the time of service as well as any other balances I may owe. Furthermore, I understand that I am responsible for payment of any non-covered service and to bring a referral if the services I receive require one from my insurance carrier. I am responsible for payment of any services received without a referral or proper authorization.

**ASSIGNMENT OF BENEFIT PROCEEDS:** I consent that the payment of third party payers from my insurer, HMO or other third party payer be made on my behalf directly to my physician.

**AUTHORIZATION OF RELEASE OF RECORDS:** I hereby authorize Benjamin M. Schwartz, MD, Anze Urh, MD, and staff to release my insurer, HMO or third party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care, if required, for pre-certification or prior approval purposes. It is however, expressly understood that there will be no obligation of the undersigned to pay for any services which are not medically necessary or improperly billed.

**ACKNOWLEDGMENT OF RECEIPT OF HIPAA CONFIDENTIALITY NOTICE:** By signing below, I acknowledge that I have received a copy of the HIPAA confidentiality notice.

_____ _____

Signature (Patient or Parent if Minor) Date

Northwell Health Physician Partners Gynecologic Oncology at Brightwaters, Port Jefferson and Huntington
404 Potter Boulevard | Brightwaters, NY 11718 | Office (631) 376-0055 | Fax (631) 376-0099

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# OTHER PHYSICIANS

PLEASE FILL OUT THIS FORM WITH YOUR CURRENT DOCTOR(S) CONTACT INFORMATION

Patient Name:_____ Date of Birth: _____

Primary Gynecologist: _____

Address:_____ City:_____

Zip code:_____ Telephone: (  ) _____

Primary Care Physician:_____

Address:_____ City:_____

Zip code:_____ Telephone: (  ) _____

Other Physicians:

Physician:_____ Specialty:_____

Address:_____ City:_____

Zip code:_____ Telephone: (  ) _____

Physician:_____ Specialty:_____

Address:_____ City:_____

Zip code:_____ Telephone: (  ) _____

Physician:_____ Specialty:_____

Address:_____ City:_____

Zip code:_____ Telephone: (  ) _____

Physician:_____ Specialty:_____

Address:_____ City:_____

Zip code:_____ Telephone: (  ) _____

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**Date of Appointment:**
**Patient Name:**
**DOB:**

**Acknowledgement of Receipt**

*I have received a copy of the Providers Notice of Privacy Practices.*

Patient/Agent/Relative Guardian* (Signature) Date/Time _____ Print Name _____ Relationship if other than patient

Telephonic Interpreter's ID# _____

OR

Signature: Interpreter _____ Print: Interpreter's Name and Relationship to Patient _____

Witness to signature (Signature) _____ Date/Time _____ Print Name _____

**Provider Use Only**

☐ Patient or patient representative refused to sign/accept Notice of Privacy Practices

☐ Patient unable to sign

Signature _____ Date/Time _____

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Authorization for Disclosure of Protected Health Information

## **PLEASE CHECK YES OR NO FOR EACH ITEM**

I authorize Northwell Health Physician Partners Gynecologic Oncology, formerly Island Gynecologic Oncology (herein referred to as Physician) to release my medical records, test results and any information pertaining to my medical care to:

| | | | |
|---|---|---|---|
| (please check) | Physicians | Yes ☐ | No ☐ |
| | Hospitals | Yes ☐ | No ☐ |
| | Insurance Company | Yes ☐ | No ☐ |
| | Family Members or Friends | Yes ☐ | No ☐ |

If yes, please list names: _____

_____

_____

I authorize the use of the following means of communication by Physician for the transfer of my medical information:

| | | | |
|---|---|---|---|
| (please check) | Telephone | Yes ☐ | No ☐ |
| | Fax Machine | Yes ☐ | No ☐ |
| | Mail | Yes ☐ | No ☐ |
| | E-mail | Yes ☐ | No ☐ |

I authorize Physician to contact me by:

| | | | |
|---|---|---|---|
| (please check) | Telephone | Yes ☐ | No ☐ |
| | Fax Machine | Yes ☐ | No ☐ |
| | Mail | Yes ☐ | No ☐ |
| | E-mail | Yes ☐ | No ☐ |

I give permission for a message to be left for me on my answering machine:

(please check) Yes ☐ No ☐

Patient Name: _____ Date of birth: _____

Patient Signature: _____ Date: _____

OR

Signature of Authorized Person: _____

Relationship to Patient: _____

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# E-Mail/Electronic Communication Consent

NSLIJ discourages the use of email to communicate about your medical matters because it is not a secure method of communication, information could potentially be sent to the wrong person, may not be the most timely method of communication and it is dependent on technology which may or may not work all time. However, if you chose to communicate with your provider regarding email, NSLIJ asks that you acknowledge and consent to the following:

I understand that e-mail communication should not be used for emergencies or for communicating time sensitive information. In the event of a medical emergency I should contact 911 or go to the nearest Emergency Department. To communicate emergent or time sensitive information I should directly contact the office of the healthcare provider.

I understand that e-mail communication will be processed during routine business hours. In the event I do not receive a response, I understand that I should contact the office directly.

I understand that due to situations outside of the control of the physician, clinicians and office practices, internet and email service may be interrupted or not work at any given time. The physicians, clinicians and office practices are not responsible for technical failures. Again, if you do not receive a response to your email, please call the office directly during business hours.

I will not share, distribute, release or sell my healthcare provider's e-mail address to anyone.

I understand that email communication is not a substitute for medical care and evaluation. I must arrange for an office appointment to assure appropriate care.

I understand that I am to provide my full name and contact information in all e-mails, e.g., full name, address, phone number(s) on each email.

I understand and accept that my provider may route my e-mail to other members of the staff for informational purposes or for expediting a response. I authorize my provider to send and designate staff to receive and read my e-mail.

I acknowledge that commonly used e-mail services are not secure and fall outside the security requirement set forth by the Health Insurance Portability and Accountability Act for the transmission of protected information. Therefore, I understand there is a risk that my health information may be obtained by others not affiliated with my provider. I authorize my provider to transmit my personal health information via email even though email may not be secure and private and may be subject to loss or exposure.

I acknowledge and accept that my healthcare provider can terminate e-mail communication services at any time.

I understand that I am responsible for notifying the physician if I chose to discontinue email communication or if my email address has changed.

E-MAIL: _____

| | | | |
|---|---|---|---|
| Patient/Agent/Relative/Guardian* Signature | Date | Print Name | Relationship if other than patient |
| Interpreter, if applicable (Signature) | Date | Print Interpreter Name or Telephonic Interpreter's ID | |
| Witness to signature (Signature) | Date | Print Name | |

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Southside Hospital
Northwell Health®

# Authorization for Access to Patient Information Through a Health Information Exchange Organization

| PATIENT NAME: | DATE OF BIRTH: | PATIENT IDENTIFICATION NUMBER: |
|---|---|---|
| PATIENT ADDRESS: | | |

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Northwell Health (including their agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

**The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.**

**My Consent Choice.** ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ 1. I GIVE CONSENT for Northwell Health to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

☐ 2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for Northwell Health to access my electronic health information through Healthix.

☐ 3. I DENY CONSENT for Northwell Health to access my electronic health information through Healthix for any purpose, *even in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

| SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE | DATE |
|---|---|

| PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE) | RELATIONSHIP OF LEGAL REPRESENTATIVE TO PATIENT (IF APPLICABLE) |
|---|---|