NEW WINDSOR
Family Medicine

Patient Demographic

Patient Information:

Last Name:_____First Name:_____MI:_____Sex M___F___

Social Security #:_____Date of Birth: ___/___/___ **(For Minors)** Parent Name_____

Street Address:_____**(For Minors)** Parent Date of Birth___/___/_____SSN:_____

City:_____State:___Zip:_____**(For Minors)** Mother Maiden Name:_____

Home #: _____ Work #: _____Ext._____ Cell #: _____Email_____

How did you hear about our practice?_____

Marital Status: S __ M __ D __ W __ Emergency Contact:_____Phone:_____Relation_____

As a result of the federal government's American Recovery and Reinvestment Act (ARRA) of 2009, there are standards that are required for the use of Electronic Health Records (EHR), which we use in our office. One of the requirements is the collection of information on patients' race and religion. As a result, we are asking patients to provide this information for inclusion in our records. You can decline to provide the information if desired by checking the decline to answer box. Thank you for your cooperation.

Race:___American Indian/Alaska Native ___Asian ___Black/African American___ Caucasion/White___ Hispanic ___Unknown ___Decline ___Other:

Religion: ___Christian ____Jewish ___Muslim ___Catholic ___Not Practicing___Decline ___Other:_____

****

Primary Insurance Information:

Insurance Company:_____Phone #:_____

Address:_____City:_____State:_____Zip_____

Policy#_____Group#_____Copay $_____

Insurance Holder Info (if not yourself):
Name_____Address_____City_____State____

Zip_____ Date of Birth: ___/___/___ Sex: M___F___Employer:_____Phone# Employer:_____

****

Secondary Insurance Information:

Insurance Company:_____Phone #:_____

Address:_____City:_____State:_____Zip_____

Policy#_____Group#_____Copay $_____

Insurance Holder Info (if not yourself):
Name_____Address_____City_____State____

Zip_____ Date of Birth: ___/___/___ Sex: M___F___Employer:_____Phone# Employer:_____

****

I authorize payment of Medicare or my present insurance carrier benefits be made directly to New Windsor Family Medicine, PLLC for services furnished to me by the provider. I authorize the release of any medical information about me to the holder to determine benefits payable for related services. I am aware that I am responsible for any unpaid balance regardless of insurance status, and also for any fees or charges incurred for returned checks, or should my account be turned over to a collection agency for non-payment of services. I acknowledge my responsibilities as a member of my insurance carrier and will comply with applicable copayments, coinsurances, and PCP requirements at the time of service.

_____ _____
Signature of Patient or Guardian Date

_____ _____
If Guardian, Please State Relationship to Patient Print Name

NEW WINDSOR
Family Medicine

PERMISSION FOR OUTPATIENT MEDICAL TREATMENT AND ACKNOWLEDGEMENT FORM

Patient_____ **Date**_____

Permission is hereby given to the physicians and other professionals of the New Windsor Family Medicine, PLLC to provide routine medical care for the above named patient, including assessment, diagnostic testing and rendering treatment.

This consent shall remain in effect for the above named patient unless withdrawn in writing.

This consent does not cover evaluation and treatment associated with motor vehicle or work injury or illness that is covered by no-fault or workers' compensation insurance. Additional consent is required for that type of care.

I hereby certify that I have read or have had explained to me the above permission and acknowledgement statements:

_____
Patient

_____ _____
Authorized Representative (see below) **Relationship to Patient**

NEW WINDSOR
Family Medicine

IMPORTANT OFFICE POLICIES

MISSED APPOINTMENT POLICY

In order for us to be available as often and as soon as possible for all of our patients, especially in an emergency situation, we ask for 24 hours notice of cancellation of an appointment. There is a **$25 charge that is paid by you** (not chargeable to your insurance company) if you miss your appointment or cancel within TWO (2) HOURS of your scheduled appointment. Often times, we have patients on a waiting list that will fill late cancellations but we need some amount of time to be able to fill in those open spots. Additionally, if we find that you repeatedly miss appointments or regularly cancel within two hours of scheduled appointments, we will ask you to find a new Primary Care Provider.

PAYMENT POLICY

We expect that any payments due while you are here for your appointment be paid at that time, unless alternate payment arrangements have been made with the business office. All pre-determined co-payments are due at your appointment. If you should incur a bill that cannot be paid in full right away, we fully expect a regular monthly payment on your account. Payment arrangements may be made with the business office but are not necessary if you are paying on your balance monthly. If after three (3) months we do not receive payment, your bill is subject to be transferred to a collection agency. If this should occur, you will not be permitted to make another appointment or receive any services until the balance is paid in full. **Insurance Waiver:** You should also understand that you are responsible for advising New Windsor Family Medicine of your current insurance. In the event that this does not happen and we are not contracted with your current company OR you have not chosen us (if appropriate to your policy) as your Primary Care Provider (PCP), you agree to pay your balance in full.

MEDICATION REFILLS

Please allow **AT LEAST** 24 hours for all medication refill requests to be processed. Depending on how much time has passed since your last visit, you may be asked to make an appointment in order to have your medication refilled.

I, _____ understand and agree to the terms of the above
(print name of responsible party)
policies. I will make every effort to abide by these policies and understand that not following the above policies may result in charges to my account and/or dismissal from New Windsor Family Medicine.

_____
(Signature of responsible party)

575 Hudson Valley Avenue • Suite 201 • New Windsor, NY 12553 • Phone: (845) 220-2270 • Fax (845) 220-2277

NEW WINDSOR
Family Medicine

Authorization for the Use and/or Disclosure of Protected Health Information

I authorize the use/or disclosure of my protected information only as directed below:
(please initial those areas authorized)

Type of information	Initial	Type of information	Initial
Appointment Information	_____	Test results	_____
Insurance information	_____	Patient's presence in office	_____
Clarify clinical information	_____	**Any and all information**	_____
Other_____	_____		

I authorize my protected health information to be shared with me via e-mail **(please initial)**:
E-mail Test Results _____
E-mail Address _____

I authorize the following entity to disclose my protected health information:
Name and address of office: **New Windsor Family Medicine, PLLC**
575 Hudson Valley Ave, Suite 201
New Windsor, NY 12553
I authorize the following person(s) to **receive** my protected health information:

Name:_____

Relationship to patient: _____

Telephone number(s): _____

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then this information would no longer be protected.
I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and I am aware that it is not effective to the extent that the person(s) I have authorized to use and/or disclose my protected health information have acted in re-liance upon it. **I understand that this person will have to use a PIN number generated by New Windsor Family Medicine in order to receive PHI.**

_____I authorize one time release of the information described above. This authorization expires when acted upon or **6 months from date of signature**.

OR

_____This authorization is for ongoing communication and remains in effect unless revokes in writing.

I do not have to sign this form in order to receive treatment from New Windsor Family Medicine I have read and understand the above and authorize disclosure of my protected health information as described.

Signature:_____ Date:_____

Name of Patient:_____ Patients Date of Birth_____

Name of Personal Representative:_____

Relationship to Patient:_____

*Parent,legal guardian, next of kin or legally appointed individual who represents the patient when the patient is:

1. Incompetent by judicial finding
2. Physically incapable
3. Mentally lacking capacity
4. A minor less than 18 years of age **UNLESS** Patient is pregnant. Patient is a parent Patient has been legally married.

NEW WINDSOR
Family Medicine

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name_____

Address_____ **City**_____ **State**____

Zip Code_____ **Phone**_____ **Date of Birth**_____ **SSN**_____

Other Name(s) Under Which Your Were Treated:_____

Records Released From:

Name_____

Address_____

_____

Phone_____ Fax_____

Records Released To:

New Windsor Family Medicine
575 Hudson Valley Ave, Suite 201
New Windsor, NY 12553
Telephone (845) 220-2270
Fax (845) 220-2277

INFORMATION TO BE RELEASED

( ) Complete copy of all records ( ) Progress notes ( ) Lab reports
( ) Radiology reports ( ) Immunization records
( ) Correspondence ( ) Billing information ( ) Other (specify)_____

For the following dates:_____

By initialing below I authorize the release of the following:

_____Mental Health Treatment/Evaluation ____HIV/AIDS Related Information
_____Drug Treatment/Evaluation ___Alcohol Treatment Evaluation

Reason for disclosure

____Further medical care ___Insurance claim ___Insurance application
____Legal Investigation ___Personal ___Other

This authorization will remain in effect until this request is processed, unless you specify that it will be effective for an additional time period. Written consent is necessary to revoke this request.
_____Additional time period (specify)
_____ Include future records during time period ___None

I authorize release of my medical records as described above. I understand that I have the right to inspect the disclosed material. A photocopy of this consent shall be valid as the original.
I have had an opportunity to read the Information Guidelines of Medical Record Disclosure.

_____
Printed Name of Patient

_____ _____
Signature Patient/Guardian **Date**

If signed by person other that patient, state relationship and authority to sign.

_____ _____
Relationship **Authority**

INFORMED GUIDELINES OF MEDICAL RECORD DISCLOSURE

New Windsor Family Medicine honors a patient's right to confidentiality of medical information as provided under federal and state law.

No Obligation to sign. Your are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, New Windsor Family Medicine may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization in writing at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that have already been made, in reliance on this authorization, before you revoke it. Your revocation must be made in writing and addressed to the facility releasing the information at the address on the reverse.

Re-release. If the person or facility authorized to receive your medical information is not a health care provider or otherwise subject to federal health privacy laws, the medical information they receive may lose its protection under federally health privacy laws and they may be permitted to re-release your medical information without your prior permission.

If you are authorizing the release of HIV-related, alcohol or drug treatment or mental health treatment information, the recipient is prohibited from re-disclosing such information without your authorization unless permitted to do so under federal or state law. You have a right to request a list of people who may receive or use your HIV related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212)306-7450. These agencies are responsible for protecting your rights.

Inspect. You have a right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records you may contact the NWFM Privacy Officer at (845) 220-2270.

Copying fees. If you are requesting release of information to other hospitals, clinics or physicians for further medical care, no copying fees will be charged. You may be asked to pay for copies you request for other reasons.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to authorize the disclosure of your medical information, if you are under the age of 18 your parent or guardian usually signs this form for you. There are situations in which this general rule does not apply. Staff of NWFM can provide further information.

NEW WINDSOR
Family Medicine

Patient Acknowledgement of Receipt Of the Notice of Privacy Practices

For

New Windsor Family Medicine, PLLC
575 Hudson Valley Avenue
Suite 201
New Windsor, NY 12553

I understand that I have certain rights to privacy regarding my protected health information (PHI) in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information will be used to treat and coordinate care, obtain payment from third-party payers for services rendered to me, and to conduct normal healthcare operations.

By signing below I acknowledge that this office has provided me with a copy of its Notice of Privacy Practices which contains a complete explanation of how my protected health information will be used and disclosed. I understand that this office has the right to change its Notice of Privacy Practices at any time and that I may be provided with a current copy at request.

I understand that I may request in writing restrictions as to how my health information can be used or disclosed to carry out treatment, payment, or operations. I also understand that New Windsor Family Medicine, PLLC is bound to my request for restrictions unless otherwise objected.

_____
Patient Name (please print)

_____
Patient Signature

_____
If other than patient, please state relationship

_____
Date

NEW WINDSOR FAMILY MEDICINE, PLLC

Notice of Privacy Practices

Effective: 12/11/2006

As a result of the Health Insurance Portability & Accountability Act of 1996 it is required that this office inform you, the patient, how health information about you may be used and disclosed and how you can get access to your health information. Please review this notice carefully.

This practice is dedicated to maintaining the privacy of your individually identifiable health information, or protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Although these laws are complicated, we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times and you may request a copy of our most current Notice at any time.

II. We may use and disclose your PHI in the following ways:

1. **Treatment** – Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as urine or blood tests), and we may use the results to help us reach a diagnosis. We might use your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including our clinicians, may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment** – Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurance carrier to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations** – Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders** – Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment Options** – Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
6. **Health Related Benefits and Services** – Our practice may use and disclose your PHI to inform you of health related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends** – Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to be seen by the doctor for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
8. **Disclosures Required by Law** – Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

III. Use and Disclosure of your PHI in Certain Special Circumstances

The following describes scenarios in which we may use or disclose your PHI:

1. **Public Health Risks** – Our practice may disclose your PHI to public health agencies that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
    - Reporting reaction to drugs or problems with products or devices
    - Notifying individuals if a product or device they may be using has been recalled
    - Notifying appropriate government agencies and authorities regarding potential abuse or neglect of an adult patient (including domestic violence) however, we will only disclose this information if the patient agrees or if we are required or authorized by law to disclose this information.
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **Health Oversight Activities** – Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings** – Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Lawful Enforcement** – We may release PHI if asked to do so by a law enforcement official regarding any of the following:
    - A crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify or locate a suspect, material witness, fugitive or missing person
    - In an emergency to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator.
5. **Deceased Patients** – Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or identify the cause of death. If necessary, we may release information in order for funeral directors to perform their jobs.
6. **Organ and Tissue Donation** – Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research** – Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when and Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the below conditions:
    - The use of disclosure involves no more than a minimal risk to your privacy based on the following:
        1. an adequate plan to protect the identifiers from improper use and disclosure
        2. an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health research justification for retaining the identifiers or such retention is otherwise required by law)
        3. Adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would be otherwise permitted.
    - The research could not practicably be conducted without the waiver.
    - The research could not practicably be conducted without the access to and use of the PHI
8. **Serious threats to health or safety** – Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military** – Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
10. **National Security** – Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We may also disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates** – Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes will be necessary for the institution to provide medical services to you, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals.
12. **Workmen's Compensation** – Our practice may release your PHI for worker's compensation and similar programs.

IV. Your Rights Regarding Your PHI

1. **Confidential Communication** – You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to the practice manager specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions** – You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the practice manager. Your request must describe in detail the information you wish restricted, whether you are requesting a limit to the practice's use, disclosure, or both, and to whom you want the limitations applied.
3. **Inspection and Copies** – You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the practice manager in order to inspect and / or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and or/ copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the reviews.
4. **Amendment** – You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practice manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit the request and reason for request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures** – All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our office may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice** – You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the front desk receptionist or the practice manager.
7. **Right to File a Complaint** – If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the practice manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide and Authorization for Other Uses and Disclosures** – Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will not longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

   Should you have any questions regarding this notice or our health information privacy policies, please contact the practice manager at (845) 220-2270.