



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 ___ Caucasian/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



**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, 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.



***Patient Authorization for Use and Disclosure of Protected Health Information
For Treatment, Payment, or Healthcare Operations***

I, _____, acknowledge that **New Windsor Family Medicine, PLLC** maintains medical information in electronic and/or paper records and that the records include my health history, symptoms, examinations, test results, diagnosis, treatment notes, consultation reports, and future treatment plans. This information will be used to aid in my treatment and care at this office as well as be used as a tool for communication to coordinate my care with other healthcare professionals. It will also be used to verify treatment with third-party payers for payment of services provided to me by **New Windsor Family Medicine, PLLC**.

I understand that I have been given a copy of their *Notice of Privacy Practices* that provides complete description of information use and disclosure by **New Windsor Family Medicine, PLLC**. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directories
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care services provided those restrictions are requested in writing to the privacy officer at **New Windsor Family Medicine, PLLC**.

I understand that **New Windsor Family Medicine, PLLC** does not have to agree to the restrictions I request. I understand that I have the right to revoke this consent in writing, except to the extent that which **New Windsor Family Medicine, PLLC** has already taken action in reliance to this notice. I also understand that by refusing to sign or revoking this consent, the office has the right to refuse to treat me in accordance to federal law.

I further understand that **New Windsor Family Medicine, PLLC** has the right to change its Notice of Privacy Practices at any time and that prior to implementation a copy of any revisions will be sent to me at the address I have provided.

I understand as a part of **New Windsor Family Medicine, PLLC's** treatment, payment, or health care operations, it may be necessary to disclose my protected health information to another entity, and I consent to permit disclosure for these purposes, including disclosures via fax, e-mail, electronic medical records, or electronic prescription ordering.

By signing below I fully understand and accept the terms of this consent.

Print Name

Date

Signature of Patient / Guardian

Relationship to the patient



AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name _____

Address _____ **City** _____ **State** _____

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

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

Records Released From:

Records Released To:

Name _____

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

Address _____

Phone _____ Fax _____

INFORMATION TO BE RELEASED

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

For the following dates: _____

By initialing below I authorize the release of the following:

- ____ Mental Health Treatment/Evaluation
- ____ Drug Treatment/Evaluation
- ____ HIV/AIDS Related Information
- ____ Alcohol Treatment Evaluation

Reason for disclosure

- ____ Further medical care
- ____ Insurance claim
- ____ Legal Investigation
- ____ Personal
- ____ Insurance application
- ____ 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 than 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. You 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 NWFPM 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 NWFPM can provide further information.