New Patient Forms

PLEASE PRINT AND COMPLEAT ALL INFORMATION

FIRST NAME:_________________________________ INITIAL:______ LAST NAME:___________________________________

ADDRESS:______________________________________ CITY: ___________________________ STATE: ________ ZIP:_________

DATE OF BIRTH: ________________ MALE ☐ FEMALE ☐ HOME PHONE: _________________ CELL: ___________________

EMAIL: ______________________________________ EMPLOYER: _________________________PHONE:__________________

PRIMARY CARE PHYSICIAN: ____ PHONE: __________________

THERAPIST / COUNSELOR: ____ PHONE: __________________

PHARMACY:_________________________________ PHONE: ________________________ FAX: _______________________

ADDRESS: ____

SPOUSE / PARENT OR GUARDIAN INFORMATION

NAME: ___________________________________ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ PHONE: ___________________

ADDRESS (IF DIFFERENT): ____ CITY: ___________________ STATE:______

ZIP:_________ DATE OF BIRTH:_______________ EMPLOYER:____

INSURANCE INFORMATION

PRIMARY INSURANCE: _________________________________ POLICY HOLDER: _____________________________________

MEMBER/POLICY #: _________________________ CLAIMS ADDRESS:____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE: ________________________________ POLICY HOLDER: ___________________________________

MEMBER/POLICY #: _________________________ CLAIMS ADDRESS:____

AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process my claims.

PAYMENT TO PROVIDER: I authorize payment of my medical benefits directly to Dr. Riaz Syed.

I understand and agree that by accepting services, I am financially responsible to Dr. Riaz Syed for payment of any of my charges that are not reimbursed by other means and agree that I am responsible for any legal or collection fees that my be incurred should my account require these services. I further understand that three cancelled or missed appointments within a year can result in termination of care, also if I do not cancel my scheduled appointment 24 hours in advance, I will be charged for the missed appointment.

GUARANTOR'S SIGNATURE: ____ DATE: _________________________

Record Release Form

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:____ **Date of Birth:** __________________
Last **First** **Middle**

<u>Authorization for Use/Disclosure of Information</u>: I voluntarily authorize and direct my health care provider (Please insert name of provider) Riaz Sibtain Syed, MD to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

<u>Recipient</u>: Name of person or class of persons to whom my health care provider may disclose my health information ____. Address or Fax # of the recipient or where my health information should be delivered:
____.

<u>Purpose</u>: I understand that the specific purpose of this Authorization is
Coordination of Care.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

<u>Information to be disclosed</u>: This authorization permits the above provider to disclose the following medical records:

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ All of my health information described above except for the following:
  ____.
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)____.

<u>Term</u>: This Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of ________, 200__.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: Written Revocation of Care

<u>Redisclosure</u>: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

<u>Refusal to sign/right to revoke</u>: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

<u>Revocation</u>: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

____ ______________________________

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____________________________ _______________ ___________ ______________________

Name of Guardian/Representative Legal Relationship Date Witness

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

OUR LEGAL DUTY

MH-CNY-FL Medical PC is required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice may be revised at any time. Any revisions will be effective for past, present and future health information we have about you. MH-CNY-FL Medical PC is required to follow the terms of the most current notice. You may request a copy of our Notice at any time. In addition, each time you begin services or are readmitted to MH-CNY-FL Medical PC you will receive a copy of the Notice.

ALL EMPLOYED AND CONTRACTED STAFF AND BUSINESS ASSOCIATES WILL FOLLOW THIS NOTICE.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We can release your information to pharmacies and labs, as well as to persons who are involved in your care such as friends and family.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals.

SPECIAL SITUATIONS - PROTECTED HEALTH INFORMATION MAY BE RELEASED WITHOUT CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT:

We may use or disclose your protected health information in the following situations without your authorization or without allowing you to object or agree to the use or disclosure.

Legal Requirements: We may use and disclose your medical information when we are required to do so by law. This includes disclosing your protected health information in response to a court order, to identify or locate a suspect, fugitive material witness or missing person, audits, investigations, inspections and licensure activities as required by State and Federal mandate.

Revised January 2018

To Report Abuse: We may disclose your medical information when the information relates to abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting or with your permission.

Public Safety: Consistent with our legal and ethical obligations we may disclose information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to yourself, identified individuals and the public or in an emergency.

Coroners, Health Examiners & Funeral Directors: For identification purposes, to determine cause of death or as necessary to carry out their duties.

Organ & Tissue Donations: If a donor to an organization that handles organ procurement.

Research: If reviewed by an Independent Review Board

Workers' Compensation: We may disclose medical information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries and illnesses.

Military and Veterans: As required by Military command authorities.

Minors: If you are an unemancipated minor under New York law, there may be circumstances in which we disclose health information about you to a parent, guardian or other persons acting in *loco parentis*, in accordance with our legal and ethical responsibilities. If you are a parent of an unemancipated minor and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. In some circumstances we may not disclose health information about an unemancipated minor to you.

EXCEPTION TO RELEASE WITHOUT CONSENT:

We will follow the provisions of 42 CFR Part 2, which severely restricts the release of protected health information if the records are from substance abuse treatment. There are special rules about releasing HIV/AIDS/STD services. This office must make special efforts to protect the names of people who receive these services.

PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. We will charge you a fee of $10.00 for the first 15 pages and $.85 per page thereafter. If we maintain an electronic record for you, you may request access to your health information in an electronic format or have the information transmitted electronically to a designated recipient. We may deny your request to inspect and copy in certain limited circumstances.

A denial will be issued in writing with instructions on how to request a review of the denial. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Notice: Receive a paper copy of this Notice no later than the date of the first service delivery, upon request and a new copy whenever it is updated.

COMPLAINTS:

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

NOTICE OF BREACH OF HEALTH INFORMATION:

In the unlikely event that your health information is inadvertently acquired, accessed, used by or disclosed to an unauthorized person, we will provide you with written notice of such a breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The written Notice will be sent by regular mail. If the contact information we maintain for you is insufficient or out-of-date, we may attempt to provide notice to you by telephone or other permissible alternate method.

PHQ-10 Self-Assessment

PHQ-10 Self-Assessment Health Questionnaire
MH-CNY-FL Medical PC

Name:
Date of Birth:
Address:
Email:
Phone Number:

Patient Health Questionnaire

The following Patient Health Questionnaire is a multipurpose self-assessment to assist your physician in screening, diagnosing, and measuring the severity of depression.
Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

- **0 - Not at all**
- **1 - Several days**
- **2 - More than half the days**
- **3 - Nearly every day**

2. Feeling down, depressed, or hopeless

- **0 - Not at all**
- **1 - Several days**
- **2 - More than half the days**
- **3 - Nearly every day**

3. Trouble falling or staying asleep, or sleeping too much

- **0 - Not at all**
- **1 - Several days**
- **2 - More than half the days**
- **3 - Nearly every day**

4. Feeling tired or having little energy

- **0 - Not at all**
- **1 - Several days**
- **2 - More than half the days**
- **3 - Nearly every day**

5. Poor appetite or overeating

- **0 - Not at all**
- **1 - Several days**
- **2 - More than half the days**
- **3 - Nearly every day**

6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

- **0 - Not at all**
- **1 - Several days**
- **2 - More than half the days**

3 - Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

0 - Not at all

1 - Several days

2 - More than half the days

3 - Nearly every day

8. Moving or speaking so slowly that other people could notice. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

0 - Not at all

1 - Several days

2 - More than half the days

3 - Nearly every day

9. Thoughts that you would be better off dead, or of hurting yourself

0 - Not at all

1 - Several days

2 - More than half the days

3 - Nearly every day

Would you be interested in learning more about a safe, effective, non-drug treatment for depression?

Yes **No**

How many anti-depressant prescription medications do you currently take or have tried in the past?

0

1

2-4

5+

Not Sure

Tele Psychiatry Form

To be completed by Provider:

Patient Name:	Date of Birth:
Patient Address:	Date Consent Discussed:

I understand that telemedicine is the use of electronic information and communication technologies by health care provider to deliver services to an individual when he/she is located at a different site that the provider; and hereby consent to providers listed below providing health care services to me via telemedicine.

I understand that the laws that protect the privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting the providers listed below. If the consent is in force (has not been revoked) the providers listed below may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

Providers:

Dr. Riaz Syed, MD
Katrina Garrigan, PA
Patricia Powers, NP

Signature of Patient (or person authorized to sign for Patient): ____________________________ *Date:* ______________________

If authorized signer, relationship to Patient: ____

Witness: ____ *Date:* ______________________

I have been offered a copy of this form (Patient's initials): _________

Health e Connections

MH CNY FL Medical PC

New York State Department of Health

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

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

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 **MH CNY FL Medical PC** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections 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 HealtheConnections website at http://healtheconnections.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 **MH CNY FL Medical PC** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).
☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **MH CNY FL Medical PC** to access my electronic health information through HealtheConnections.
☐ **3. I DENY CONSENT** for **MH CNY FL Medical PC** to access my electronic health information through HealtheConnections for any purpose, ***even** in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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)

Details about the information accessed through HealtheConnections **and the consent process:**

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: **315-480-2997**; or visit HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation. If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**