NEW YORK SURGICAL PARTNERS

Tele: 516-627-5262
Fax: 516-627-0641

PATIENT INFORMATION SHEET

Have you ever been seen in the past by our Doctors? **YES** or **NO**

Who is your appointment with today?

- ☐ Daniel Popowich, MD
- ☐ Jonathan Zagzag, MD
- ☐ Gary Gecelter, MD
- ☐ Eugene Rubach, MD
- ☐ George DeNoto, MD
- ☐ Michael Giuffrida, MD
- ☐ Mitchell Chorost, MD

Patient Name: ____________________

Street: ____________________ City: ____________________ State/Zip: __________

Home Phone: ____________________ Cell Phone: ____________________ DOB: __________

Social Security: ____________________ Gender: Male / Female Marital Status: S M D W Spouse's name: __________

Employer: ____________________

Employer's Address: ____________________ City: ____________________ State/Zip: __________

Business Number: ____________________ Email Address: ____________________ @

☐ I agree to be contacted via email about confidential health information

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Prefer Not to Answer
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Other: __________

Who Referred you? ____________________ Phone: ____________________

Address: ____________________

In Case of Emergency Notify: ____________________ Phone: __________

Relationship: ____________________ Work Phone: __________

Primary Insurance Company: ____________________

Address: ____________________ City: ____________________ State/Zip: __________

Identification# ____________________ Group#: ____________________ Co-Pay: __________

Policyholder's Name: ____________________ Relationship: ____________________

Policyholder's SS# ____________________ Policyholders DOB: ____________________

Insurance Plan Effective Date: __________ Does your insurance require a referral from your Primary Care? Y or N

Secondary Insurance Company: ____________________

Address: ____________________ City: ____________________ State/Zip: __________

Identification# ____________________ Group#: ____________________ Co-Pay: __________

Policyholder's Name: ____________________ Relationship: ____________________

Policyholder's SS# ____________________ Policyholders DOB: ____________________

Insurance Plan Effective Date: __________ Does your insurance require a referral from your Primary Care? Y or N

***Note: Address, DOB & SS# of policyholder is required if other than yourself.**

Assignment of Benefits

I hereby authorize St. Francis Surgical Associates, PC to release all information required by my insurance to process my claims.
I hereby authorize assignment of benefits to be paid directly to St Francis Surgical Associates, PC
This arrangement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original
I understand that I could be financially responsible for all non-covered medical services.

Patient Signature: ____________________ Date: __________

A copy of your insurance card is required for our files and a Co-Payment may apply at the time of visit - Rev-1/9/19

NYSP NEW YORK SURGICAL PARTNERS
Hernia Institute · Cancer Center · Gastrointestinal Center

NEW YORK SURGICAL PARTNERS

Today's Date: ____________________

Name: ____________________ (LAST) ____________________ (FIRST)

Date of Birth: ____________________

Primary Care Physician: ____________________

What is the reason for your visit? ____________________

GENERAL
- ☐ Loss of Weight
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Sweats

SKIN
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Hives/itching
- ☐ Rash

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swollen Ankles
- ☐ Varicose Veins
- ☐ Shortness of Breath

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control

MUSCULOSKELTAL
- ☐ Joint Pains
- ☐ Paralysis/Weakness
- ☐ Muscular Pain
- ☐ Fractures
- ☐ Herniated Discs

EYE, EAR, NOSE, THROAT
- ☐ Persistent Cough
- ☐ Ringing in the Ears
- ☐ Sinus Problems

SCREENINGS

Date of last Pap Smear: ____________________

Have you had a Colonoscopy: ☐ YES ☐ NO

If yes, date of last Colonoscopy: ____________________

Have you had a Mammogram? ☐ YES ☐ NO

If yes, date of last Mammogram ____________________

Have you had an Upper Endoscopy? ☐ YES ☐ NO

If yes, date of last Upper Endoscopy: ____________________

CONDITIONS: Check conditions you have now or had in the past

☐ Alcoholism	☐ Drug Dependency	☐ Herpes	☐ Pacemaker
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pneumonia
☐ Appendicitis	☐ Emphysema	☐ High Cholesterol	☐ Prostate Disease
☐ Arthritis	☐ Epilepsy	☐ Kidney Disease	☐ Psychiatric Care
☐ Asthma	☐ Glaucoma	☐ Liver Disease	☐ Rheumatoid Fever
☐ Bleeding Disorders	☐ Goiter	☐ Migraine Headaches	☐ Stroke
☐ Breast Lump	☐ Gout	☐ Infectious Disease	☐ Thyroid Problems
☐ Bronchitis	☐ Heart Disease	☐ Mononucleosis	☐ Tuberculosis
☐ Cataracts	☐ Hepatitis	☐ Multiple Sclerosis	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Osteoporosis	☐ Other ________

FAMILY HISTORY: List all medical history pertaining to each family member

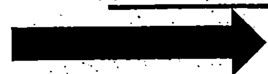
MOTHER: ____________________ FATHER: ____________________

MATERNAL GRANDPARENTS: ____________________ PATERNAL GRANDPARENTS: ____________________

SIBLINGS: ____________________

Have you ever have a blood transfusion? ☐ YES ☐ NO If yes, please give approximate date(s) ____________

(PLEASE TURN OVER)



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NEW YORK SURGICAL PARTNERS

Today's Date: ____________________

Name: ______________________________________ Date of Birth: ____________________
LAST FIRST

MEDICATIONS: Including Vitamins and Herbal Medications

Medication	Dose	Frequency

ALLERGIES: List allergies to medication(s) or substances(s) Describe your allergic reaction

Allergy	Reaction

HOSPITALIZATIONS/SURGERIES:

Year	Reason for Hospitalization / Surgery	Hospital Name

HEALTH HABITS: Fill out all that apply

Substance	How Much	How Often	Date of Last Use
Caffeine			
Tobacco			
Recreational Drugs			
Alcohol			

I Certify that the above information is correct to the best of my knowledge. I will not hold my Physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of these forms

Patient / Representative Signature · Print Name / Relationship · Date

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Last Four (4) Digits of SS#
Patient Address	Phone Number	MR#

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* INFORMATION** only if I place my initials on the appropriate line in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information, I 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 my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in item 2), and this redisclosure may no longer be protected by federal or state law.

FOR OFFICE USE ONLY Boxes 6-12

6. Name and address of health provider or entity to release this information

7. Name and address of person(s) or category of person to whom this information will be sent

8. Specific information to be released:

☐ Medical Record from (insert date) ____________ to (insert date) ____________

☐ Entire Medical Record

☐ Other: ____________

include: (indicate by Initialing)

____ Alcohol/Drug Treatment

____ HIV Related Information

____ Mental Health Information

9. Reason for release of information:

☐ Persona Use ☐ Medical Care ☐ Attorney

☐ Insurance ☐ Other

10. This authorization will expire within 1 year of the signature date unless specified:

11. If not the patient, name of person signing form:

12. Authority to sign on behalf of patient:

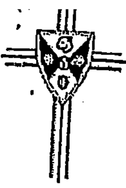
All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X ______________________ ______________ ______________

Signature of Patient or Representative authorized by law | Date | Time

A COPY of this Authorization shall have the same force and effect as an original

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could indentify someone as having HIV symptoms or infection and information regarding a person's contacts.



Catholic
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At the heart of health

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. CHS Physician Partners, P.C. may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit CHS Physician Partners, P.C. to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

____________________ ____________________
(relationship to me)

____________________ ____________________
(relationship to me)

____________________ ____________________
(relationship to me)

____________________ ____________________
(relationship to me)

____________________ ____________________
(relationship to me)

I expressly permit CHS Physician Partners, P.C. to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

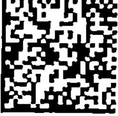
Home answering machine: Tel.#: ____________________

Office voicemail: Tel.#: ____________________

Other (specify): ________________ Tel.#: ____________________

☒ ____________________ ____________________
Signature of Patient
Personal Representative
Parent/Guardian

(Date)



Catholic Health Services of Long Island
At the heart of health

Admission Forms - SCAN, NOTICE OF PRIVACY PRAC, 7/11/19

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the end of this notice, and how I may obtain access to and control this information.

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative

____
Date / Time

____
Description of Personal Representative's Authority

____
Signature of Facility Representative Date / Time

Catholic Health Services of Long Island
At the heart of health

Healthix

HIE - SCAN, HIE CONSENT, 9/2/19

CATHOLIC HEALTH SERVICES OF LONG ISLAND HEALTH INFORMATION EXCHANGE (HIE), CARE EVERYWHERE, CAREQUALITY AND HEALTHIX CONSENT FORM

The Catholic Health Services of Long Island ("CHS)" Data Warehouse (the "Data Warehouse"), Care Everywhere, Carequality and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website **www.ehealth4ny.org**.

In this Consent Form, you can choose whether to allow CHS to share your medical records with your non-CHS health care providers and to allow CHS to access information about care provided to you by non-CHS providers through the following health information technology platforms. These platforms can help collect the medical records you have in different places where you get health care and make them available electronically to the providers treating you. Your consent choice on this form will apply to all of the platforms.

CHS Data Warehouse: You can Give or Deny consent to allow the participants (their employees, agents or members of their medical staff) with which CHS has established connectivity ("HIE Participants") to access your electronic health information maintained in the CHS Data Warehouse, including records from your other healthcare providers authorized to disclose information through the CHS HIE.

Epic Care Everywhere, Sequoia Project, and Carequality: You can give consent to allow the health care providers, their employees, agents or members of their medical staff, listed on the Epic website **www.epic.com/careeverywhere** and Sequoia Project website **https://carequality.org/active-sites-search/** to access your health information maintained in the CHS electronic medical record systems.

Healthix: You can Give or Deny consent to allow CHS (our employees, agents or members of our medical staff) to see and obtain access to your electronic health records from your other healthcare providers authorized to disclose information through Healthix. **Healthix** is a Health Information Exchange or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the State of New York. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at **http://www.healthix.org** or by calling Healthix at 877-695-4749.

Upon request, your provider will print the participating provider/information sources lists for you from the websites. The lists are updated regularly.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE. PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices: You can fill out this form now or in the future. You can also change your decision at any time by **completing** a new form. You have the following choices below. Please check Box 1, 2 or 3:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants with which CHS has established connectivity to access ALL of my electronic health information available through the CHS Data Warehouse, to ALL of the providers listed on the Epic and Sequoia Project websites to access ALL of** my **CHS** electronic health records, and **to ALL employees, agents and members of the medical staff of CHS to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants with which CHS has established connectivity to access** my electronic health information through the **CHS Data Warehouse, except for information they created,** and **I DENY CONSENT to ALL employees, agents and members of the medical staff of CHS to access ANY of** my electronic health information through **HEALTHIX contributed by a non-CHS participant** for any purpose, *even in a medical emergency*. I understand that I may be asked by Care Everywhere and Carequality providers at the point of care for authorization to access my CHS electronic health information and they may access my information in an emergency as allowed by applicable law.

☐ **3. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY to ALL of the HIE Participants with which CHS has established connectivity to access my health information through the CHS Data Warehouse, to ALL of the**

CATHOLIC HEALTH SERVICES OF LONG ISLAND HEALTH INFORMATION EXCHANGE (HIE), CARE EVERYWHERE, CAREQUALITY AND HEALTHIX CONSENT FORM

providers listed on the Epic and Sequoia websites to access All of my **CHS** electronic health records, and **to ALL employees, agents and members of the medical staff of CHS to access ALL of** my electronic health information through **HEALTHIX**.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your health information available through the CHS Data Warehouse and Healthix. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by applicable law. **Checking the "I DENY CONSENT" box will not prohibit Epic Care Everywhere and Carequality providers from accessing your CHS electronic health information in an emergency as allowed by applicable law.**

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.

Print Name of Patient | Patient Date of Birth

Signature of Patient or Patient's Legal Representative | Date | Time

Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)

CHS HIE Care Everywhere and Healthix
Fact Sheet

Details about patient information in the CHS Data Warehouse, Care Everywhere and Healthix and the consent process:

1. **Definitions.**

- "The Catholic Health Services of Long Island" refers to:
  - Beacon Health Partners, LLP
  - Beacon IPA, LLC
  - Catholic Home Care
  - CHS Physician Partners ACO II, LLC
  - CHS Physicians medical practices
  - Good Samaritan Hospital Medical Center
  - Good Samaritan Nursing Home
  - Good Shepherd Hospice
  - Maryhaven Center of Hope
  - Mercy Medical Center
  - Our Lady of Consolation Nursing & Rehabilitative Care Center
  - St. Catherine of Siena Medical Center
  - St. Catherine of Siena Nursing & Rehabilitation Care Center
  - St. Charles Hospital & Rehabilitation Center
  - St. Francis Hospital
  - St. Joseph Hospital
- "Participants" refers to the entities with which CHS has established connectivity through Epic, Sequoia Project and Healthix.

Catholic Health Services of Long Island

Patient Authorization, Assignment of Benefits & Financial Agreement

PATIENT NAME (PRINT):	DATE OF BIRTH:	EFFECTIVE DATE:

I acknowledge and understand that by signing below, I hereby authorize payment directly to New York Surgical Partners - 2200 Northern Blvd, Suite 125, East Hills, NY 11548 - Telephone: 516-627-5262 Fax: 516-627-0641 for services rendered to me, as specified more fully below.

1. **MEDICARE:**
   - I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
   - I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
   - I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
   - The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
   - I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
   - My authorization will remain in effect unless I revoke my authorization in writing.

2. **OTHER INSURANCE PLAN PARTICIPATION:** The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.
   - I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
   - I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
   - I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES:** I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.
   - I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
   - I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
   - I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION:**
   - I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
   - I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. **FINANCIAL AGREEMENT:**
   - In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
   - If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
   - If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
   - If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
   - ***I agree to be primarily responsible for the payment of the Practice's bill.***

______________________________ Beneficiary Signature or Authorized Party

______________________________ Date

NYSP NEW YORK SURGICAL PARTNERS

Hernia Institute · Cancer Center · Gastrointestinal Center

PHYSICIANS PARTICIPATING IN YOUR CARE

Patient Name: ______________________ **Date:** __________ **Date of Birth:** __________

Please complete all that apply:

TYPES	PHYSICIAN NAME		TELEPHONE NUMBER	OFFICE ADDRESS
	FIRST	LAST		
Primary Care Physician				
Cardiologist				
Gastroenterologist				
Pulmonologist				
Hematologist/Oncologist				
Endocrinologist				
Nephrologist				
Any other specialist(s)				

Name of the physician that referred you to our office: ______________________

Please provide your pharmacy information:

Name of Pharmacy: ______________________

Phone number: ______________________

Addres: ______________________

MY CHART ACTIVATION FORM

USER NAME (6 CHARCTERS) MUST CONTAIN ONE UPPERCASE LETTER AND MAY CONTAIN ONE NUMBER AND/OR SPECIAL CHARACTER

____

PASSWORD (8 CHARACTERS) ***MUST CONTAIN ONE UPPERCASE AND ONE NUMBER AND ONE SPECIAL CHARACTER***

____

BIRTHDATE ______________________________

EMAIL ADDRESS: ______________________________

CHOOSE **ONE**:

NAME OF YOUR FIRST PET: ______________________________

FAVORITE PERSON FROM HISTORY: ______________________________

MAKE OF YOUR FIRST CAR: ______________________________

CLOSEST CHILDHOOD FRIEND: ______________________________

https://mychart.chsli.org