MIDDLETOWN MEDICAL
Your health care… all in one place!

Patient Information

TODAY'S DATE:_____ **ACCT#**_____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PARENT'S NAME (IF CHILD)_____

MAILING ADDRESS: _____APT.#:_____CITY:_____

STATE: _____ ZIP CODE:_____PH #:_____CELL#_____WORK#_____

E-MAIL ADDRESS: _____ Would you like to sign up for out patient portal? Yes____ No____

SEX: M____ F____ AGE: _____ SOCIAL SEC. #:_____-_____-_____

RACE: _____ **ETHNICITY:** ____ **NON-HISPANIC OR LATINO** ____ **HISPANIC OR LATINO** **PREFERRED LANGUAGE:**_____

EMERGENCY CONTACT: _____EMERGENCY CONTACT PHONE:_____ **HIPAA APPROVED YES** or **NO**

PRIMARY CARE PHYSICIAN:_____SPECIALIST PHYSICIAN::_____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: _____

POLICY ID #:_____ GROUP #:_____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT:_____

DOB: _____ SS#:_____-_____-_____ POLICY HOLDER'S EMPLOYER:_____

EMPLOYER ADDRESS: _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME: _____

POLICY ID #:_____ GROUP #:_____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT:_____

DOB: _____ SS#:_____-_____-_____ POLICY HOLDER'S EMPLOYER:_____

EMPLOYER ADDRESS: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHARMACY ADDRESS: _____ PHONE:_____

PATIENT CONSENT FOR EXTERNAL PRESCRIPTION HISTORY

I, _____ , whose signature appears below, authorize Middletown Medical, PC and Its Affiliated Providers to view my external prescription history via the Rx Hub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Patient Signature (Parent/Guardian must sign if patient is a minor) **Date**

PATIENT CONSENT/ ACKNOWLEDGEMENT

CHARGES FOR SERVICES RENDERED: All charges for office services are due at the time of my visit to Middletown Medical, PC. If an insurance claim is filed by Middletown Medical, PC, I request that payment of all benefits be made on my behalf to Middletown Medical, PC.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

Notice Of Privacy Practices I acknowledge that I have r been provided with a copy of Middletown Medical's Notice of Privacy Practices

SHARING/DISCLOSING HEALTH INFORMATION: I acknowledge that I have received Middletown Medical P.C. Notice of Practices. I authorize Middletown Medical, PC to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or healthcare operations). I further authorize Middletown Medical, PC to gain access to medical records with information relevant to my treatment from any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

TREATMENT: I further authorize and consent to Middletown Medical, PC's physicians and their assistants and other professional staff providing medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

EMERGENCY MEDICAL CARE: In the event that a life-threatening emergency occurs while I am in attendance at Middletown Medical, PC in which emergency medical care or treatment is required, I hereby authorize Middletown Medical, PC and its related providers to arrange for the care and treatment necessary to address my emergency medical condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment and I agree to be responsible for all medical and related costs associated with such emergency and follow-up medical treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier and/or health care plan to make payment to Middletown Medical, PC and hereby assign to Middletown Medical, PC any and all rights, title and interest I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by Middletown Medical, PC, its physicians and their assistants and other professional staff providing medical treatment, supplies, services, equipment and other items. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain precertification for services. I understand that I am financially responsible to Middletown Medical, PC for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or on my behalf. If, for whatever reason, my insurance company and/or health care plan should remit payment directly to me for any medical treatment, supplies, services, equipment or other items rendered to me by Middletown Medical, PC, I shall promptly endorse the check to Middletown Medical, PC and mail to the address below. Checks received by Middletown Medical, PC with joint payees, shall be endorsed to Middletown Medical, PC within five (5) days. In the event that I should cash a check received by me, which is intended as payment to Middletown Medical, PC for services rendered, and retain the proceeds for personal use, I understand I will be subject to 1% interest per month (calculated on the total amount due), all legal costs and termination of treatment through Middletown Medical, PC. **IF NO PAYMENT IS RECEIVED WITHIN SIXTY DAYS, MIDDLETOWN MEDICAL, PC HAS THE RIGHT TO TURN MY ACCOUNT OVER TO COLLECTION. ALL LEGAL COSTS INCURRED WILL BE MY RESPONSIBILITY.**

_____ _____

Signature of Patient / Parent / Legal Guardian **Date**

_____ _____

Name of Patient / Parent / Legal Guardian **Relationship to Patient**

_____

Patient's Name (if signed by Parent or Legal Guardian)

AUTHORIZATION: COMMUNICATION OF CONFIDENTIAL INFORMATION

45 CFR §164.506(b)(1)

In order to effectively communicate with you regarding your medical treatment and health information, we request that you complete this form, to authorize those means of communication which provide the best ways for us to communicate with you regarding your confidential information. We may need to communicate with you about billing information, appointment information and medical / health information including, but not limited to lab test results, x-ray results, prescription information, diagnostic information or to otherwise respond to requests or messages left for your physician. We have the ability to communicate with you using the below methods, and will do so, based on your authorization, as indicated below.

Please check each of the boxes that you give Middletown Medical, PC permission to use for your communications:

○ You may contact me by telephone	Phone Number(s): _____
○ You may leave a message / voicemail*	Phone Number(s): _____
○ You may contact me by mail	

*** I authorize Middletown Medical, PC, its physicians and employees to leave detailed messages specific to my medical care including test results on the phone number(s) listed above. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access.**

If you would like to grant permission for Middletown Medical, PC to communicate your confidential information to anyone besides you, please provide their details below, including what type of information (in the "Options" column) you would like us to be able to share with the listed individuals:

Name	Phone Number	Relationship	Options
			○ Billing Information
			○ Appointment Information
			○ Medical / Health Information
			○ Billing Information
			○ Appointment Information
			○ Medical / Health Information
			○ Billing Information
			○ Appointment Information
			○ Medical / Health Information
			○ Billing Information
			○ Appointment Information
			○ Medical / Health Information

This authorization supersedes any prior "AUTHORIZATION: COMMUNICATION OF CONFIDENTIAL INFORMATION" I may have completed.

I understand that this authorization can be revoked at any time by submitting a written request to Middletown Medical, PC. Unless revoked sooner, this authorization will expire one (1) year from the date listed above.

_____ _____

Signature of Patient / Parent / Legal Guardian **Date**

_____ _____

Name of Patient / Parent / Legal Guardian **Relationship to Patient**

_____

Patient's Name (if signed by Parent or Legal Guardian)

Middletown Medical P.C.

Authorization for Access to Patient Information
New York State Department of Health 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 the Organization named above 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/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on 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

Please check the box of your 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 the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ 2. I DENY CONSENT for the Organization named above 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 HIV/AIDS
   - Birth control and abortion (family planning)
   - Mental health conditions
   - Genetic (inherited) diseases or tests
   - 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 and 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 directly by accessing their contact information on the 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 (or until 50 years after your death, whichever occurs first). 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.

NAME _____ SEX _____ DATE_____
AGE _____ RACE_____ HEIGHT_____ WEIGHT_____ SHOE SIZE_____
OCCUPATION/JOB DESCRIPTION _____
FAMILY PHYSICIAN_____ PCP PHONE _____

PERSONAL HISTORY – NOT FAMILY

€ ANXIETY PROBLEM	€ HEART TROUBLE	€ RHEUMATIC FEVER
€ ARTHRITIS Type:_____	€ HEPATITIS Type:_____	€ SEIZURES/EPILEPSY
€ ASTHMA	€ HIGH BLOOD PRESSURE	€ SICKLE CELL ANEMIA
€ BLEEDING DISORDERS	€ HIGH CHOLESTEROL	€ SKIN PROBLEMS Type:_____
€ CANCER	€ IMMUNE DEFICIENCY DISORDER	€ STOMACH ULCERS
€ CIRCULATORY DISEASE	€ KIDNEY TROUBLE	€ STROKE SIDE: R L
€ DEPRESSION	€ LIVER DISEASE	€ THYROID PROBLEM ↑ ↓
€ DIABETES Type:_____	€ LOW BLOOD PRESSURE	€ OSTEOPOROSIS
€ GOUT	€ NERVOUS CONDITION	€ OTHER:_____
		_____

ALLERGIES

€ ASPIRIN	€ IODINE	€ PENICILLIN
€ CODEINE	€ LATEX	€ SULPHER/SULPHITES
€ ENVIRONMENTAL	€ LOCAL ANESTHESIA	€ TAPE ON SKIN
€ FOODS	€ NOVOCAINE	€ OTHER: _____

PAST SURGICAL HISTORY

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)_____		5)_____	
2)_____		6)_____	
3)_____		7)_____	
4)_____		8)_____	

PRESENT MEDICATIONS (List the medication and what illness the medication is prescribed for)

NAME OF MEDICATION	ILLNESS	NAME OF MEDICATION	ILLNESS
1)_____		6)_____	
2)_____		7)_____	
3)_____		8)_____	
4)_____		9)_____	
5)_____		10)_____	

FAMILY HISTORY – NOT YOURS (Only parents, grandparents, brothers and sisters)

€ ARTHRITIS	€ CIRCULATORY DISEASE	€ HIGH BLOOD PRESSURE
€ BLEEDING DISORDER	€ DIABETES	€ PROBLEM WITH ANESTHESIA

SOCIAL HISTORY

TOBACCO (PKS/DAY) _____ COFFEE/TEA (CUPS/DAY) _____ ALCOHOL _____
DO YOU TAKE ASPIRIN REGULARLY? IF SO, HOW MUCH? _____
HAVE YOU EVER FAINTED? IF SO, WHY? _____