

REGISTRATION FORM

Today's Date:	PCP:
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PATIENT INFORMATION

Patient's last name:		Patient's first name:		Patient's middle name:	
Marital status:	Birth date:	Sex: <input type="radio"/> Male <input type="radio"/> Female	Email:		
Address:					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by (Please choose one option):		<input type="radio"/> Doctor: <input type="radio"/> Other:			

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
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PREFERRED DISCLOSURE CONTACT

<input type="checkbox"/> Home telephone _____ <input type="checkbox"/> O.K to Leave message with detailed information <input type="checkbox"/> Leave message with call - back number only <input type="checkbox"/> Email _____ <input type="checkbox"/> O.K to send Email	<input type="checkbox"/> Written Communication <input type="checkbox"/> O.K to mail my home address <input type="checkbox"/> O.K to send Email <input type="checkbox"/> O.K to fax to this number <input type="checkbox"/> Other: _____ _____
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REGISTRATION FORM

CONSENT FOR TREATMENT

I hereby authorize Delmont Medical Care or its representatives to provide medical care, such as to conduct routine examinations, to obtain specimens, including blood, to perform such tests and administer treatments including the injection of pharmaceutical products (medications) and immunizations to myself as may be deemed necessary now and on subsequent visits.

X _____
Patient/Guardian/Responsible Party signature

Date

CONSENT FOR TREATMENT

Delmont Medical Care has further explained the medical care provided and that during the course of the medical care, unforeseen conditions may be revealed than those that may have been listed above. I herewith authorize and request that the above named physicians, their associates and/or assistants provide medical care or as they deem necessary in the exercise of their medical judgement. I am aware that I have the right to secure a 2nd opinion, and that I have been given the opportunity to ask all the questions I have regarding any of the aforementioned medical care. I understand that the practice of medicine is not an exact science, and I acknowledge that I have received no guarantees about the benefits or results of this care. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. All blank spaces have been completed or lined out prior to my signing this document.

X _____
Patient/Guardian/Responsible Party signature

Date

PRIVACY NOTICE

I acknowledge that I have been provided with a copy of Delmont Medical Care's Privacy Notice and have been given an opportunity to read and ask questions about the notice. I acknowledge that I have been provided a copy of the Delmont Medical care Patient Bill of Rights and have been given an opportunity to ask questions.

X _____
Patient/Guardian/Responsible Party signature

Date

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

I hereby authorize and direct the above named medical facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign transfer, and set over to the above-named facility, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to me or my dependent at the said facility. I am aware that my insurance carrier, governmental agencies or others who are financially liable has been billed by Delmont Medical care. If payment for services rendered is sent directly to me, I will forward a copy of the check and explanation of the benefits along with my payment to reimburse Delmont Medical Care.

X _____
Patient/Guardian/Responsible Party signature

Date

REGISTRATION FORM

CONSENT TO DISCUSS TREATMENT

I _____ give consent to _____ Dr. DELMONT / DMC _____ to discuss my medical condition, prognosis and treatment with:

Print name and relationship of person you are allowing

Contact information

X _____
Patient/Guardian/Responsible Party signature

Date

Denied

CONSENT TO TREAT A MINOR

For pediatric patients only

****NOTE****: THIS CONSENT DOES NOT APPLY TO ROUTINE PHYSICAL EXAMINATIONS AND/OR VACCINATIONS
PARENTS/GUARDIANS MUST BE PRESENT

I _____ consent to the treatment of _____

who is a minor, under the age of 18 years old for medical treatment accompanied by:

(Print name of designated adult)

Relationship to Patient

Date

Signature Parent/ Guardian

CONSENT FOR UNACCOMPANIED MINOR

****NOTE****: THIS CONSENT DOES NOT APPLY TO ROUTINE PHYSICAL EXAMINATIONS AND/OR VACCINATIONS
PARENTS/GUARDIANS MUST BE PRESENT

I _____ consent to the treatment of _____

who is a minor, under the age of 18 years without being accompanied by an adult, parent and/or guardian

Date

Signature Parent/ Guardian



REGISTRATION FORM

CONSENT FOR EMAIL AND/OR TEXT COMMUNICATION

Email and text messaging allows Delmont Medical Care health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you would like us to send you email and/or text messages that contains your health information, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging we will continue to use U.S. Mail or telephone to communicate with you.

X _____
Patient/Guardian/Responsible Party signature

Date

Print (name)

Email address and/or text messaging number to which your Delmont Medical Care provider may send YOU your health information (please print)

Email address and/or text messaging number to which your Delmont Medical Care provider may send YOUR PERSONAL REPRESENTATIVE your health information (please print)



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

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* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

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

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

9(a). Specific information to be released:
 Medical Record from (insert date) _____ to (insert date) _____
 Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
 Other: _____ Include: *(Indicate by Initialing)*
 _____ **Alcohol/Drug Treatment**
 _____ **Mental Health Information**
 _____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____
 Initials Name of individual health care provider
 to discuss my health information with my attorney, or a governmental agency, listed here:

 (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: At request of individual Other:	11. Date or event on which this authorization will expire:
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12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
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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.

 Signature of patient or representative authorized by law. Date: _____

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



REGISTRATION FORM

Delmont Medical Care Authorization for Access to Patient Information Through a Health Information Exchange Organization

New York State Department of Health

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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 **Delmont Medical Care** (including their agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix 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 Healthix's website at www.healthix.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.

<p>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.</p>
<p><input type="checkbox"/> 1. I GIVE CONSENT for Delmont Medical Care to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).</p>
<p><input type="checkbox"/> 2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for Delmont Medical Care to access my electronic health information through Healthix.</p>
<p><input type="checkbox"/> 3. I DENY CONSENT for Delmont Medical Care to access my electronic health information through Healthix for any purpose, <i>even in a medical emergency</i>.</p>

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.

Signature of Patient or Patient's Legal Representative	Date
X	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)