DELMONT MEDICAL CARE

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	Patient's first name:	Patient's middle name
Marital status:	Birth date:	Preferred Language: ○ Spanish ○ English ○ Other
Address:		Social Security no.:
Home phone no.:	Cell phone no.:	Email:

Gender identity:
○ Male ○ Female ○ Other
○ Choose not to disclose

Sexual Orientation:
○ Straight ○ Lesbian / Gay ○ Bisexual
○ Other ○ Choose not to disclose

Race: ○ American Indian or Alaska Native ○ Asian Indian ○ Black or African American
○ Other ○ Other Asian ○ Patient Refused ○ White or Caucasian

Ethnicity: ○ Hispanic or Latino ○ Unknown
○ Not Hispanic or Latino ○ Choose not to disclose

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Student – Full Time
○ Not Employed ○ Retired ○ Disabled ○ Student – Part Time, Never

Chose clinic because/referred to clinic by (Please choose one option):
○ Doctor:
○ 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.:

PREFERRED DISCLOSURE CONTACT

☐ Home telephone_____
- ☐ O.K to Leave message with detailed information
- ☐ Leave massage with call - back number only

☐ Email _____
- ☐ O.K to send Email

☐ Written Communication
- ☐ O.K to mail my home address
- ☐ O.K to send Email
- ☐ O.K to fax to this number

☐ Other:_____
_____

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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

DELMONT MEDICAL CARE

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 ROUNTINE 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 ROUNTINE 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

DELMONT MEDICAL CARE

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)

OCA Official Form No.: 960

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:
12. If not the patient, name of person signing form:	13. 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.

_____ Date: _____

Signature of patient or representative authorized by law.

* **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.**

Delmont Medical Care

New York State Department of Health

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

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** 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 to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

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 **Delmont Medical Care** to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for **Delmont Medical Care** to access my electronic health information through Healthix for any purpose.

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

Delmont Medical Care

No-Show Fee Agreement

To provide timely care and accommodate as many patients as possible, our GYN office has implemented a **$50 no-show fee for missed appointments**. Please read and sign this agreement to acknowledge your understanding and acceptance of this policy.

1. **No-Show Fee:** I understand that I will be charged a $50 fee if I fail to attend my scheduled appointment without providing at least 24-hour notice to cancel or reschedule.
2. **Notice Requirement:** I agree to notify the office at **least 24 hours in advance** if I need to cancel or reschedule my appointment. I understand that I can contact the office by phone at 516-377-8014 or via Text.
3. **Payment Responsibility:** I acknowledge that the no-show fee is my responsibility and is not covered by insurance. The fee must be paid before I can schedule another appointment.
4. **Exceptions:** I understand that exceptions may be considered for emergencies or other valid reasons, at the discretion of the office manager. I agree to contact the office as soon as possible if I miss my appointment due to an emergency.

By signing below, I acknowledge that I have read and understand this no-show fee agreement and agree to its terms.

Patient Signature: _____ **Date:** _____

Patient Name (Print): _____ **DOB:** _____