# OBSTETRICS & GYNECOLOGY

**TODAY'S DATE**:___/___/___ **PHYSICIAN**:_____ **UNIT#**: ___-___-___
**NAME**:_____ Date of Birth:___/___/___ Age:_____

Address:_____ Apt.:_____ Social Security#:___/___/___

City, State:_____ Zip Code:_____

Telephone: (_____)_____ (_____)_____
EVENING DAYTIME
Occupation:_____ Employer:_____
Marital Status: Married_____ Single_____ Separated_____ Divorced_____ Widowed _____
Country of Birth:_____ Primary Language:_____
**Domestic Partner's Name**:_____
Domestic Partner's Occupation:_____

Mother's First Name: _____ Father's First Name:_____
Emergency Contact Name:_____ Telephone#:_____ Relation: _____
Who referred you to this office?_____
EMAIL ADDRESS: _____

**PRIMARY INSURANCE**:_____ Effective Date:___/___/___
Insurance Carrier's Address (on back of card):_____
Policy/ID Number:_____ Group/Plan Number:_____
Name of Subscriber if different from Patient:_____ Relation: _____
Date of Birth of Insured Party:_____ Co-Payment:_____
IF APPLICABLE
**SECONDARY INSURANCE**:_____
Insurance Carrier's Address (on back of card):_____
Policy/ID Number:_____ Group/Plan Number:_____
Name of Subscriber if different from Patient:_____ Relation:_____
Date of Birth of Insured Party:_____ Co-Payment:_____
IF APPLICABLE
PHARMACY NAME:_____ PHARMACY TELEPHONE #:_____

## MEDICARE

I request that payment of authorized MediCare benefits be made either to me or on my behalf to New York Physicians, LLP for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____
Patient Signature Date

## COMMERCIAL INSURANCE

I authorize New York Physicians, LLP to act as my agent to help obtain payment from my insurance carrier(s). This includes my authorization to release information to my insurance company(ies), use this form, or a copy of this form in place of the original, process all insurance submissions, and for my insurance carrier to directly reimburse New York Physicians, LLP for services rendered. I understand that although New York Physicians, LLP will help to process insurance claims, I am responsible for my bill.

_____
Patient Signature Date

# GYNECOLOGY INTAKE FORM

Name_____ Date of Birth _____ Today's Date _____
Email Address: _____

Referring Physician Name & Address _____
Primary Care Physician (if different) _____
Pharmacy# Primary: _____ Alternate: _____

**What is the reason for your visit today?** Is this a routine visit? Yes __ No __
_____
_____
_____

Describe the problem
_____
_____

When did it start? _____ What does it feel like/what are the symptoms? _____
_____

How severe are the symptoms? (1-10) _____ Where are they located? _____
What makes it better or worse? _____
Have you been taking medications for this problem? _____
Have there been previous episodes? _____
Did you seek previous medical care of this problem? _____

**Do you have any allergies to medications or other substances? Yes __ No __**
**If yes, please list allergies and reactions (rash, hives, throat swelling, anaphylaxis)**
**_____**
**_____**

Please list **ALL** of your current medications below (use back of page if you need more room)

| MEDICATION NAME | DOSAGE | WHEN DO YOU TAKE IT? | APPROXIMATE START DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**OB/GYN HISTORY:**
Number of pregnancies _____
Live births ____ Vaginal Deliveries ____ Cesarean Sections ____ Miscarriages ___
Tubal Pregnancies ____ Terminations ___ Living Children _____

When was your last menstrual period? _____ Age of first period _____
How frequently do you have your period? _____
If irregular, describe frequency _____ Is your flow heavy? _____
How many days do you bleed? _____ Do you stain/bleed between regular periods? _____
Do you have pain with periods? _____ If so, describe: _____

If your periods have stopped do you have any symptoms associated with menopause?
Yes ___ No ___ If yes, describe _____
_____

Are you currently sexually active? Yes ___ No ___

Do you have any problems associated with sexual relations? Yes ___ No __
If yes, Describe:
_____

Are you currently in a monogamous relationship? Yes ___ No ____
If yes, partners gender: M __ F __ How long have you been in the relationship? _____
Age at first time of intercourse: _____ Approx. number of partners: _____

Are you currently using birth control? Yes ___ No ___
Trying to get pregnant? Yes ___ No ____
Current birth control: _____ Are you satisfied with it? Yes ___ No ___
Describe any side effects:
_____

When was your last PAP Smear? _____
Have you ever had an abnormal PAP? Yes __ No __ If yes, When? _____
If you were told you had HPV describe how you were treated: _____
_____

Have you ever been treated for the following? If yes, please check.
Vaginosis ___
Genital Warts ___
Chlamydia ___
Herpes ___
Trichomonas ___
Gonorrhea ___
Syphilis ___
Have you ever been tested for HIV? Yes ___ No ___ When? _____

**MEDICAL HISTORY:** Have you ever had (been diagnosed or treated for) any of the following (if yes, describe)

| | YES | NO | DESCRIBE |
|---|---|---|---|
| HEART DISORDER | | | |
| STOMACH/INTESTINAL DISORDER | | | |
| SKIN DISORDER | | | |
| CLOTTING DISORDER | | | |
| EYE DISORDER | | | |
| PSYCHIATRIC DISORDER | | | |
| URINARY/KIDNEY DISORDER | | | |
| LIVER DISORDER/ HEPATITIS | | | |
| ORTHOPEDIC DISORDER | | | |
| CHOLESTEROL DISORDER | | | |
| NEUROLOGIC DISORDER | | | |
| DIABETES | | | |
| HIGH BLOOD PRESSURE | | | |
| ARTHRITIS | | | |
| FIBROIDS | | | |
| ENDOMETRIOSIS | | | |
| CANCER | | | |
| THYROID DISORDER | | | |
| LUNG DISORDER | | | |
| NEUROLOGIC DISORDER | | | |
| OTHER | | | |

**SURGICAL HISTORY**: List any surgeries you have had and the approximate date:
Appendectomy _____ Laparoscopies _____
Gallbladder _____ Abdominal Surgeries _____
Tubal Ligation _____ Hysterectomy _____
Breast Surgeries _____ Ovaries Removed Yes ___ No __
Others: _____

Have you had a blood transfusion? Yes __ No __ If yes, when? _____

**HEALTH MAINTENANCE/DIAGNOSTIC HISTORY**
Last Mammogram _____ Normal __ Abnormal __
Last Bone Density _____ Normal __ Abnormal __
Last Cholesterol _____ Normal __ Abnormal __
Last Colonoscopy _____ Normal __ Abnormal __

**FAMILY HISTORY:** Please indicate any major conditions/illnesses that your family members have had

| | Condition & Description | Living | If deceased, what age? |
|---|---|---|---|
| Mother | _____ | _____ | _____ |
| Father | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ |

| CONDITION | | WHICH RELATIVE: |
|---|---|---|
| Cancer Breast: | Yes __ No __ | _____ |
| Cancer Colon: | Yes __ No __ | _____ |
| Cancer Cervix: | Yes __ No __ | _____ |
| Cancer body of uterus: | Yes__ No __ | _____ |
| Cancer ovaries: | Yes __ No __ | _____ |
| Cancer other: | Yes __ No __ | _____ |
| High Blood Press. | Yes __ No __ | _____ |
| Heart Disease | Yes __ No __ | _____ |
| Stroke | Yes __ No __ | _____ |
| Diabetes Mellitus | Yes __ No __ | _____ |
| Thyroid Disease | Yes __ No __ | _____ |

Other: _____

**SOCIAL HISTORY:**

Occupation: _____
Who do you live with at home? _____
Marital Status: _____
Do you exercise regularly? Yes __ No __ Describe routine: _____
Do you have pets in your home? Yes __ No __ Describe: _____
a healthcare proxy? Yes __ No __

***Tobacco:*** Currently? Yes __ No __ Previously? Yes __ No __
Yrs Smoked ____ Packs/Day ____
Are/Were you exposed to 2nd hand smoke at home or work? Yes __ No __
If yes, Explain: _____

**Other substances:**
Alcohol? Yes __ No __ Recreational drugs? Yes __ No __
Describe Use _____

**Patient Signature:** _____ **Date**: _____

635 Madison Avenue ● New York, New York 10022

# NOTICE OF PRIVACY PRACTICES

***EFFECTIVE APRIL 14, 2003***

**As Required by the Privacy Rule and related Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")**

**THIS NOTICE OF PRIVACY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU, OUR PATIENT, MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CONFIDENTIAL *PROTECTED HEALTH INFORMATION*.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

## A. OUR COMMITMENT TO YOUR PRIVACY

New York Physicians LLP is dedicated to maintaining the privacy of your individually identifiable health information and, more specifically, your protected health information (PHI). In providing health care services to you, we will create records regarding you and matters related to treatment, payment, and operations related to our care and services to you. We are required by law to maintain the confidentiality of PHI that can identify you. We are also required by law to provide you with this notice of our legal duties and the privacy practices and procedures. By federal and state law, we must follow the terms of this Notice of Privacy Practices that we have in effect at any given period in time.

These laws are complicated, but we want you to have a clear understanding of how we use and safeguard your PHI in several aspects of our practice:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligations concerning the use and disclosure of your PHI

**This Notice of Privacy Practices applies to all records containing your PHI that are created or retained by our practice, including electronic, written, an oral forms. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You will be provided with an updated Notice of Privacy Practices if such changes are significant. Our practice will post a copy of our current Notice of Privacy Practices (hereinafter, "Notice") in our offices in a visible location at all times. You may request a copy of our most current Notice at any time.**

## B. ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES

A copy of this Notice is provided to each patient of New York Physicians LLP. As a patient of ours, you are asked to acknowledge receipt of this Notice by signing the attached "Acknowledgement Form for Receipt of Notice of Privacy Practices" (hereinafter, "Acknowledgement"). Under HIPAA, we are required to furnish you with a copy of this Notice and make it available to you for subsequent inspection. We are also required to provide such an Acknowledgement for your signature, but the Acknowledgement Form only **confirms that you have received the Notice of Privacy Practices**. However, you are ***not required to sign*** this

Acknowledgement, though we are required to note in our files any refusal you might indicate to sign this Acknowledgement.

## C. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, CONTACT:

**Privacy Officer**
**New York Physicians LLP**
**635 Madison Avenue**
**New York, New York 10022**

## D. AUTHENTICATION OF PATIENT OR DESIGNEE(S)

New York Physicians LLP staff will seek to authenticate the individuals with whom they are communicating via telephone and in person. This procedure may lead you to our staff members asking you a series of questions so that we may reasonably validate that you are in fact the patient or designee with whom we expect we are communicating. As an example, if you call us on the phone, we will ask you the following questions:

First Name
Last Name
Date of Birth
Last Four (4) Digits of Social Security Number

We may possibly ask you for other key identifying information if you are calling about a billing statement or other type of correspondence. Such additional information might include an account number or visit ID number or some other unique identifying information that can assure us that we are, in fact, speaking with the appropriate individual.

For designees whom you may ask to act on your behalf, we require you to provide us a signed authorization that details the following information regarding any and all designees:

First Name
Last Name
Date of Birth
Last Four (4) Digits of Social Security Number

and in some cases, we may ask your designee other qualifying information.

## E. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

**1. Treatment**. Our practice may use your PHI to treat you. For example, we might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our physicians and clinical staff – may use or disclose your PHI in order to treat you or to assist others in your treatment (e.g. providing relevant information to obtain pre-certification from your insurer). Additionally, we may also disclose your PHI to other health care providers for purposes related to your treatment. Finally, **only with your written authorization**, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

**2. Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, and pre-authorize payment for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as a family member who is the guarantor of your financial account. We may also use your PHI to bill you directly for services and items.

**3. Health Care Operations**. Our practice may use and disclose your PHI to operate our business and to support the core functions of treatment and payment. For example, our practice may use and disclose PHI in evaluating the quality of equipment used in the care you received from us, or to conduct business planning activities for our practice. If this involves services of another business entity, we will have a written contract to ensure that such organizations also protect the privacy of your PHI. There are specific situations in which we might have to use your PHI in our operations (Please see Section G, Paragraph 1 on **Confidential Information** in the event that you wish restriction of any processes described herein):

- When contacting you to remind you of an appointment, we may have to leave a message on your voice mail, at the primary contact phone number you designate. In this case, we will leave a message asking you to call our staff member or physician and the phone number to return the call.

- From time to time we may send to you a reminder in the mail or via electronic means. In the case of a reminder in the mail, we will provide such information in an enclosed envelope. In the case of an electronic voice reminder, we will contact your primary phone number with a brief message as to our practice name and the date/time of your appointment.

- In our office we may use your PHI in a variety of ways, including calling your name and using your PHI for a variety of support activities such as making referrals, scheduling procedures, ordering lab tests, and so forth.

**4. Appointment Reminders and Correspondence**. Our practice may use and disclose your PHI to contact you and remind you of an appointment you have with us by telephone or written correspondence. If necessary, we will leave you a voice message. Our correspondence to you in general will include a return address with your physician's name and/or the name of our practice. In all situations, we will disclose the minimum necessary information in such communications. You may restrict the type of information disclosed or the nature of any such disclosure in these forms of communication by contacting our staff to request a form for such restriction.

**5. Treatment Options**. Our practice may use and disclose your PHI to evaluate potential treatment options or alternatives for you.

**6. Health-Related Benefits and Services**. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**7. Release of Information to Family/Friends and Caregivers**. Our practice may release your PHI, **with your written authorization**, to a friend or family member involved in your care, or to someone who assists in taking care of you. For example, you may have a home health aide or one of your [adult] children accompany you for your visit with one of our providers for treatment of a medical problem; these individuals may have access to your medical information, **if you so authorize**.

**8. Release of Information to Personal Representatives or Individuals with Health Care Power of Attorney.** Our practice may release your PHI, without your written authorization, to an individual with your health care power of attorney. We may also release your PHI to a Personal Representative, who is authorized under state or other applicable law to act on your behalf in making health care related decisions (e.g. court appointed legal guardian, executor of estate). We will not disclose information to a Personal Representative if such disclosure is reasonably likely to cause harm to you.

**9. Emergencies.** Our practice may disclose your PHI to your emergency contact in the event of an emergency, provided that appropriate authentication of such a designee is possible.

**10. Communication Barriers**. Our practice may disclose your PHI in order to communicate with you should there be communication barriers.

**11. Transport of Records.** Our practice may transport your PHI from time to time to other locations of our practice or to locations outside our practice in order to maintain our operations. On these occasions, persons outside the practice will not have access to your PHI or will be under contract to preserve the confidentiality of your PHI.

**12. Referring to You by Your Name.** Our practice will refer to you by your last name or first name only or as we are directed by you. This will occur in calling you into the treatment area and/or conducting other business with you while you are at our practice.

**13. Open Environment and Our Expectations Regarding Privacy**. Parts of our practice are in an open physical environment; we conduct our operation as discretely as reasonably feasible. We expect all our patients to respect the privacy of other patients of our practice.

**14. Non-Disclosure of PHI about an Unemancipated Minor.** New York State law prohibits the disclosure about an unemancipated minor to a parent, guardian, or other persons acting *in loco parentis*.

**15. Special Protection for HIV, Substance Abuse, and Mental Health Information.** Special, more stringent, privacy protections under various federal and state laws apply to these categories of information. Some parts of this Notice of Privacy Practices may not apply and the policies and procedures regarding those situations may be more stringent.

**16. Disclosures Required By Law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law and/or as directed by court order.

## F. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks**. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices as required by the FDA

- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness, or medical surveillance.

**2. Health Oversight Activities**. Our practice may disclose your PHI to government agencies authorized to conduct audits, investigations, and inspections of our practice. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare, and compliance with government regulatory programs and civil rights laws.

**3. Medical Malpractice Claims, Lawsuits and Similar Proceedings**. Our practice may use or disclose your PHI to support our medical malpractice insurance carrier as such organization attempts to respond to potential or actual claims under our medical malpractice coverage. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law Enforcement**. We may release PHI if ordered to do so by a judicial and/or law enforcement official:
- If you are a victim of crime in certain situations, and if we are unable to obtain your authorization
- Concerning your death if believed to have been resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

**5. Deceased Patients**. Our practice may release PHI to a medical examiner or coroner, in the unfortunate event of your death, to identify you or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their responsibilities.

**6. Organ and Tissue Donation**. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**7. Research**. In most cases, we will ask for your written authorization before using your PHI to conduct research. However, under some circumstances, we may use and disclose your PHI without your authorization if we obtain a waiver of authorization through a special process to ensure minimal risk to your privacy. This special process must satisfy the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

**8. Serious Threats to Health or Safety**. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military**. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Workers' Compensation**. Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries if you have provided written consent to these programs to receive such information.

## G. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

**1. Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to us specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to us at New York Physicians LLP, Attention: Privacy Officer. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

**3. Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to New York Physicians LLP, Attention: Privacy Officer, in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to New York Physicians LLP, Attention:

Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor may share information with the nurse, or the billing department may use your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to New York Physicians LLP, Attention: Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact New York Physicians LLP, Attention: Privacy Officer.

**7. Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact New York Physicians LLP, Attention Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

**8. Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact New York Physicians LLP, Attention: Privacy Officer**.**

## H. INCIDENTAL DISCLOSURES OF PHI

It is possible that one of our staff members or a physician may accidentally disclose your PHI in the course of treatment, payment, or operations. Such incidental disclosures are not intended and my occur as a result of response to circumstances in which you, the patient, play a role or take part. Otherwise, such incidental disclosures might occur in the situation where another patient or other person accidentally overhears or sees information concerning your PHI.

In the event that your PHI is disclosed due to an incidental situation, we will take every reasonable effort to mitigate the distribution or dissemination of your PHI.

In the event that you overhear or see PHI of another patient, we ask that you immediately report such a disclosure to a staff member or physician so that we may document the circumstances and inform the appropriate patient. We ask that you immediately disregard any such incidental disclosures and protect the confidence of such information.

# ACKNOWLEDGEMENT FORM

# NOTICE OF PRIVACY PRACTICES

## *EFFECTIVE APRIL 14, 2003*

**This Acknowledgement Form is provided to you as required by the Privacy Rule and related Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")**

**You are asked to sign this form so that we can confirm that you have received it. Your signature only confirms that you have received this Form. Your signature does not mean that you agree with any of the policies and procedures outlined herein.**

**You may refuse to sign this Acknowledgement Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not signing.**

**I acknowledge that I have received a copy of New York Physicians LLP Notice of Privacy Practices, as of the date indicated below.**

_____

**Name of Patient**

_____ _____

**Signature of Patient** **Date Signed**

**____ If checked, please see reverse side or page 2 for Patient's Refusal to Sign**

# PATIENT'S REFUSAL TO SIGN ACKNOWLEDGEMENT FORM NOTICE OF PRIVACY PRACTICES

*EFFECTIVE APRIL 14, 2003*

**The patient listed below refused to sign the Acknowledgement Form for New York Physicians LLP Notice of Privacy Practices. As a staff member of New York Physicians LLP, I am notating that the patient refused to sign the Acknowledgement Form on the date specified and for the reason listed (if given by patient).**

_____

**Patient's Name**

_____

**Staff Member's Name**

_____ _____

**Staff Member's Signature** **Date**

**REASON FOR REFUSAL:** _____

_____

_____

_____

## NEW YORK PHYSICIANS LLP

## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize New York Physicians LLP to use and/or disclose PHI about me to the following person(s) and entity(ies):

**PLEASE CHECK and specify name if desired:**

____ Spouse/Domestic Partner

_____

____ Guarantor

_____

____ Emergency Contacts

_____

____ Adult Children

_____

____ Family member, specify name & relationship:

_____

_____ Significant other, specify name:

_____

____ Translator

_____

____ Health attendant

_____

____ Private nurse

_____

____ Fitness trainer

_____

____ Administrative/personal assistant

_____

____ Other, specify name & relationship:

_____

I authorize New York Physicians LLP to use and/or disclose the information I mark:

**PLEASE CHECK, NOT COMPLETE**

____ **All of the information below**

____ Name

____ Address

____ All dates

____ Telephone number

____ Fax number

____ Electronic mail and/or IP address

____ Social Security number

____ Medical record number

____ Health plan beneficiary number

____ Account # with us, any other identifying #

____ Medications

____ Office and/or hospital notes

____ Diagnosis

____ Diagnostic test results

____ Prognosis and treatment plan

____ Outstanding account balance

The information will be used or disclosed at my request. This authorization will be valid until I revoke it in writing or note its expiration here.

I do not have to sign this authorization in order to receive treatment from New York Physicians LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: New York Physicians LLP, 635 Madison Avenue, New York, New York 10022.

Signed by: _____ _____

Signature of Patient/Patient Representative Relationship to Patient

_____ _____

Print Patient or Patient Representative's Name Date

**PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AU**