PATIENT INFORMATION

PATIENT NAME ______________________________ DATE OF BIRTH ____/____/____
Last First MI Month Day Year

ADDRESS ______________________________
Street Apt # City State Zip Code

SOCIAL SECURITY# ______-______-______ SEX __________ MARITAL STATUS ______________
Female/ Male Single/ Married/ Widowed/ Divorced

PHONE NUMBERS (___)____________ (___)____________ (___)____________
Home Work Ext Cell

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME ______________ TELEPHONE (___)____________ (___)____________

RELATIONSHIP ______________

REFERRING PHYSICIAN

NAME ______________

ADDRESS ______________

TELEPHONE ______________

PHARMACY

NAME ______________

ADDRESS ______________

TELEPHONE ______________

SHOULD A REPORT BE SENT? ______________

INSURANCE INFORMATION

PRIMARY CARRIER ______________ IDENTIFICATION #______________

GROUP NUMBER ______________ EMPLOYER NAME ______________

ADDRESS______________

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT__________ BIRTHDATE __________

ARE WE THE PRIMARY PHYSICIAN? __________ **IF NOT, WHO IS?** ______________

SECONDARY INSURANCE ______________ IDENTIFICATION # __________GROUP # __________

ADDRESS______________

NAME OF INSURED ______________ RELATIONSHIP TO PATIENT__________ BIRTHDATE __________

I AUTHORIZE THE USE OF THIS FORM ON ALL OF MY INSURANCE SUBMISSIONS. I AUTHORIZE RELEASE OF INFORMATION TO ALL OF MY INSURANCE CARRIERS. I AUTHORIZE MY PHYSICIAN TO ACT AS MY AGENT IN HELPING ME TO OBTAIN PAYMENT FROM MY INSURANCE CARRIERS. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY ENTIRE BILL, INCLUDING THE DEDUCTIBLE, IF ANY. I AUTHORIZE THE INSURANCE COMPANY TO REMIT PAYMENT FOR ANY UNPAID FEES DIRECTLY TO THE PHYSICIAN. I AUTHORIZE A COPY OF THIS DOCUMENT TO BE USED IN PLACE OF THE ORIGINAL. I HAVE READ AND AGREED TO THE ABOVE.

SIGNATURE ______________________________ DATE______________

Patient Name (Last, First, Middle): ______________________ Date: ______________

■ MEDICAL INFORMATION

Please state the reason(s) for your visit today: ______________________________

____

____

Primary Care Physician's Name ______________________________

Address ______________________________ Phone ______________

Please list all the medications you are presently using:

Medication name:	Dosage:	Frequency taken:

Please list all medications you are allergic to:

____

____

____

For office use only.

■ DOCTOR'S NOTES:

DAVID L. KAMELHAR, MD, PLLC AND ERIC S. TELLER, MD / KAMELHAR-TELLER PULMONARY MEDICINE
38 East 32nd Street, Suite 601 (at Park Avenue South), New York, NY 10016 Tel: 212-685-6611 / Fax: 212-685-6626

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

We would like to share the following policies with you so that you understand your responsibility regarding our charges for the services rendered to you.

1. If we participate with your insurance carrier as a network member, we will bill your carrier for all charges for services rendered. This includes both your primary and secondary insurance carriers. You will be responsible at the time of service for payment of:
   a. Annual deductible;
   b. Co-payments / Co-insurance; and
   c. Charges for non-covered services

   You are responsible to obtain <u>all</u> necessary referrals, pre-certifications or other required documentation prior to your appointment. It is your responsibility to keep track of how many visits you are allowed with each referral, as well as the referral's expiration date. As a courtesy, we will attempt to provide you with reminders, but it is your responsibility to keep track of your health plan's requirements. By calling the number on your insurance card, you can speak with a customer service representative to confirm your benefits and obligations. If, at the time of your visit, this office determines that your plan requires a prior approval and you do not provide such referral, authorization or certification, you may be required to sign an appropriate waiver or services may not be provided. Furthermore, in any event, if your health plan requires a prior approval, services are rendered, and you do not provide the required referral, authorization or certification, you will be wholly responsible for all charges that are not paid by your insurance carrier. You are responsible to produce your insurance cards and photo identification at each visit, upon request.

2. If your primary coverage is Medicare, and your secondary or tertiary coverage is with a commercial carrier that is not an insurance carrier with which we participate as a network member, as a courtesy we will file the claim with the other carrier(s). However, if payment is not received from the other carrier(s) within 50 days, you will be responsible for any balance charged.

3. If you have coverage with an insurance carrier with which we do not participate ("out-of-network"), **payment is due at the time of service**. We will provide you with a receipt that you can submit to your carrier for reimbursement, if applicable.

Please be advised of New York Penal Code, Section 176.05
A fraudulent health care insurance act is committed by any person who, knowingly and with intent to defraud, present, ... a claim for payment, services or other benefit pursuant to such policy, contract or plan, which he knows to: (a) contain materially false information concerning any material fact thereto; or (b) conceal, for the purpose of misleading, information concerning any fact material thereto ... The failure to provide accurate information as to your insurance coverage, or the obtainment of services through deception, such as by misstatements, or by the false use of insurance IDs, constitutes a fraudulent act. Such acts are also subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

Your signature below signifies that you have read and understand the above, and accept your responsibility regarding charges incurred in this office.

I fully understand and accept my financial responsibility for the charges I or my dependents may incur at this office.

Signature: ______________________________ Date: ________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ________________ Relationship to Patient: ________________

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PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(_ _ _) _ _ _ - _ _ _ _ Home / Office / Cell / Other: ____________

(_ _ _) _ _ _ - _ _ _ _ Home / Office / Cell / Other: ____________

(_ _ _) _ _ _ - _ _ _ _ Home / Office / Cell / Other: ____________

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse.

♦ I agree that my PHI may be shared with the following other people:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to David L. Kamelhar, MD, PLLC.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print): ______________________________

Signature: ______________________________ Date: ______________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ______________ Relationship to Patient: ______________

Please add Practice name

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

***Patient MRN/Patient ID in EMR

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In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This 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.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. 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 this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE 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 ehealth 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.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYULMC HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center 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 listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

______________________ ______________________
PRINT Name of Patient | Patient Date of Birth

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

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

Please fax 917-829-2096