



PATIENT REGISTRATION

PATIENT INFORMATION

Name: (Last, First, MI)			
Address:			
City:	State/Province:	Zip:	Country:
Mailing Address (if different from above):			
Home Phone:		Work:	Mobile:
Email:	SSN:	Birth Date:	Sex: M ☐ F ☐
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐			
Race: White ☐ Hispanic ☐ Black/African American ☐ Other Pacific Islander ☐ Other ☐ Asian ☐ Native Hawaiian ☐ American Indian ☐			
Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐		Language:	
Contact Preferred: Home ☐ Work ☐ Mobile ☐		Leave Message: Yes ☐ No ☐	
Allow Appointment Reminder: If Yes, please choose one method Call ☐ Text ☐ No ☐			
Primary Care Physician:		Referring Physician:	
Pharmacy Name/Address/Phone:			

EMPLOYER INFORMATION

Employer Name:		Phone Number:	
Address:			
City:	State/Province:	Zip:	Country:

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:
Phone:	Email:

POLICY INFORMATION

Patient is the Insured:	Yes ☐	No ☐	(if no complete the Insured fields below)	
Insured Name:		Relationship to Patient:		
Insured Address:				
City:		State:	Zip:	Country:
Insured Home Phone:		Work:		Mobile:
Insured Birth Date:	Insured Sex: M ☐ F ☐		Insured SSN:	
Insured Employer Name:			Insured Employer Phone Number:	
Insured Employer Address:				
City:		State:	Zip:	Country:
Primary Insurance				
Policy Number:		Insurance Company Group Name:		
Effective Date:	Expiration Date:		Policy Copay:	
Secondary Insurance				
Policy Number:		Insurance Company Group Name:		
Effective Date:	Expiration Date:		Policy Copay:	
Tertiary Insurance				
Policy Number:		Insurance Company Group Name:		
Effective Date:	Expiration Date:		Policy Copay:	

NOTICE OF PRIVACY PRACTICES

Purpose of this notice: To describe how your medical information is used, whom it is disclosed to and how you gain access to it.

Stony Brook Community Medical as a healthcare provider is permitted by law to collect, use and disclose your "protected health information" or medical record for the purpose of treatment, payment, internal business operations or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information.

Stony Brook Community Medical, PC agrees to abide by the terms of this notice but reserves the right to change the terms at any time. Should we do so, we will notify you in writing.

Use and Disclosure of Protected Health Information (PHI): When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family and the community we take care of. Your physician, office staff and others outside of Stony Brook Community Medical i.e. your insurer are allowed access to this information.

Some examples of uses and disclosures of your protected health information are for:

- Treatment by your doctor
- Law enforcement
- Workers compensation
- Appointment reminders
- Payment for your treatment by you or your insurance
- Reporting adverse events of medication or medical devices to the FDA
- Reporting health risks
- Response to legal proceedings
- Organ or tissue donation
- Coroners, funeral directors
- Stony Brook Community Medical to determine if we meet the needs of our patients

Any other uses and disclosures not specified require an authorization, including for marketing purposes and disclosures that constitutes the sale of PHI.

Patient Rights:

- You have the right to inspect and to obtain a copy of your protected health information for as long as the group maintains your record.
*We are permitted by NYS law to charge you a fee of 75 cents per page
- You have the right to restrict or to limit the use of your protected health information that we use for treatment, payment or operations.
*Stony Brook Community Medical reserves the right to deny you treatment should you restrict the use of your protected health information for treatment, payment or operations, unless the requested restriction relates to disclosures to a health plan and the Protected Health Information relates to a health care service or item which you have paid for in full and out of pocket.
- You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
- You have the right to request an accounting of disclosures made of your health information.
*Your request must be submitted in writing, specifying dates and time periods as far back as six years from today, as long as the events in question happened after April 12, 2003.
- You have the right to amend your protected health information.
*To amend your health information, your request must be given in writing along with a reason for doing so. Your request can be denied if the information originated outside Stony Brook Community Medical, PC.
- You have the right to request confidential communications as long as it is done in writing
*For example, you can specify that we only contact you at work, at home or by mail, etc.
- You have the right to receive notifications whenever a breach of your unsecured PHI occurs.

If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to our Compliance Officer.

Acknowledgement of Receipt of
Stony Brook Community Medical's Privacy Practices

I, the undersigned, acknowledge that I have received a copy of Stony Brook Community Medical's Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's *Compliance Officer*.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Authorization for the Release of Patient Health Information to a Second Party

I authorize the release of my Patient Health Information to my
(Fill in name(s) of all that apply.)

Spouse, _____	Ph: _____
Family Member, _____	Ph: _____
Friend, _____	Ph: _____
School/College Health Services, _____	Ph: _____
Other, _____	Ph: _____

By signing below, I acknowledge that this authorization is valid until it is revoked by me.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient a minor): _____

Print name of Parent/Guardian: _____



Healthix

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 members of the Stony Brook Organized Health Care Arrangement (listed on Exhibit A) (referred to as the "SBOHCA" or "Provider Organization") to obtain access to my medical records through the Statewide Health Information Network of New York (SHIN-NY) via 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 Health Information Exchange (HIE) organization, certified by the NYSDOH, 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 Part 2 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.

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 the SBOHCA to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).
☐ 2. I DENY CONSENT for SBOHCA to access my electronic health information through Healthix for any purpose, <i>even in a medical emergency</i> .

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)

Details about the information accessed through Healthix and the consent process:



1. **How Your Information May be Used.** Your electronic health information will be used only for the following health care 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 listed may access ALL of your electronic health information available through Healthix. 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	• Sexually transmitted diseases	• Living Situation
• Birth control and abortion (family planning)	• Diagnostic information	• Social Supports
• Medication and Dosages	• Allergies	• Claims Encounter Data
• Genetic (inherited) diseases or tests	• Substance use history summaries	• Lab Test
• HIV/AIDS	• Clinical notes	• Trauma history summary
• Mental health conditions	• Discharge summary	
	• Employment Information	
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, current list is available from Healthix. You can obtain an updated list at any time by checking Healthix's website at www.healthix.org or by calling 877-695-4749.
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 Healthix 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, contact the Provider Organization at: hipaa@stonybrookmedicine.edu or Healthix at compliance@healthix.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, until such time as Healthix ceases operation or until 50 years after your death, whichever occurs first. If Healthix 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 Healthix 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.
10. **Copy of Form.** You are entitled to get a copy of this Consent Form.



EXHIBIT A MEMBERS OF THE SBOHCA

The following entities are members of the SBOHCA

1. Stony Brook University Hospital, including:
 - Stony Brook Children's Hospital
 - Stony Brook Southampton Hospital
 - Stony Brook Eastern Long Island Hospital
2. University Faculty Practice Corporations. To review the list of all participating providers please visit the following webpage <https://www.stonybrookmedicine.edu/locations>
3. SB Community Medical, PC. To review the list of all participating providers please visit the following webpage <https://www.stonybrookmedicine.edu/community-medical/practices>
4. Meeting House Lane Medical Practice, PC



AGREEMENTS FOR PHYSICIAN PRACTICES

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Financial Agreement/Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital/University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits. I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital/professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

I understand that if I have any questions about my bills I may call:

- 631-444-4151 for Patient Accounts/Hospital Billing
- 631-444-4800 for CPMP Physicians Billing

Release of Information: I consent to the release of all or part of my health record, including my Social Security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital/University Faculty Practice Corporations to obtain reimbursement for my care. I also understand that my Social Security number may be provided to the New York Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

Release of Information to Primary Care Provider & Uniform Assignment

Release of Information to Primary Care Provider: I authorize Stony Brook University Hospital, and University Faculty Practice Corporations staff to disclose health care-related information to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital/University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.



AD2N538



AGREEMENTS FOR PHYSICIAN PRACTICES

The following section **ONLY** pertains to Medicare patients.
Patients signing this form who have Medicare Benefits understand that this
information is included for their signature.

MEDICARE

Medicare Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to the physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.



AD2N538

AGREEMENTS FOR PHYSICIAN PRACTICES

Privacy Acknowledgement

Privacy Acknowledgement: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV-related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

I have read this entire document and I understand it. I have been given the chance to ask questions and I understand that I may ask more questions at any time.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X

Signature of Patient (or representative)

Relationship (if other than Patient)

Time

Date

Print Name of Witness

Title or Relationship to Patient

X

Signature of Witness

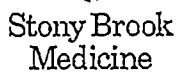
Time

Date

**My Signature indicates approval related to my care and treatment by the University
Faculty Practice Corporations (UFPCs) listed:**

Stony Brook Anaesthesiology, UFPC
Stony Brook Children's Service, UFPC
Stony Brook Dermatology Associates, UFPC
Stony Brook Emergency Physicians, UFPC
Stony Brook Family and Preventive Medicine, UFPC
Stony Brook Internists, UFPC
Neurology Associates of Stony Brook, UFPC
New York Spine & Brain Surgery, UFPC
University Associates in Obstetrics & Gynecology, UFPC

Stony Brook Ophthalmology, UFPC
Stony Brook Orthopaedic Associates, UFPC
Stony Brook Pathologists, UFPC
Stony Brook Psychiatric Associates, UFPC
Stony Brook Radiation Oncology, UFPC
Stony Brook Radiology, UFPC
Stony Brook Surgical Associates, UFPC
Stony Brook Urology, UFPC



Documentation of Interpreter or Special Assistance

An interpreter or special assistance was used to obtain consent from this patient as follows:

- ☐ Foreign Language (*specify*) _____
- ☐ Sign Language
- ☐ Visually Impaired
- ☐ Other (*specify*) _____

Interpretation or special assistance provided by _____
(Fill in name of interpreter and title or relationship to patient)

X _____

Signature of Witness	Time	Date
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Verbal Consent

When verbal consent is given, whether by telephone or in person, the person giving consent/agreement/acknowledgement or refusal clearly states their name, date of birth and relationship to the patient. This is documented clearly on the general consent and agreements form.

I _____, verify my name as stated. My address is _____, _____
(Name) (Street Address) (City, Village, Hamlet)

My phone number is _____, my date of birth is _____, and my relationship to
the patient is _____.

Further, all verbal consent, whether by telephone or in person is witnessed by two staff members working at any of the campus locations of Stony Brook Hospital.

Print Name of Witness 1	X	Signature of Witness 1	Time	Date
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Print Name of Witness 2	X		
	Signature of Witness 2	Time	Date



PP2C697

**GENERAL CONSENT
FOR TREATMENT FOR
AMBULATORY PRACTICES**

My signature below indicates my agreement and understanding of:

1. **General Consent for Treatment:** I consent for _____
(practice name)
and its staff, physicians and other practitioners (collectively, the "Practice") to provide and perform such medical care, tests, procedures and other services that are needed or helpful by the Practice for my health and well-being. I understand that this consent will be in effect for one year.
2. **Telehealth Services:** I understand that I may elect to receive certain services via Telehealth and I should inform my practitioner if I am interested in this option.
3. **Responsibility for Patient Care:** I understand that a practitioner is responsible for my care and that he/she may assign doctors, practitioners and staff as deemed appropriate to provide care to me. I also understand that, since the Practice is a teaching site, medical, nursing, social work and other students may observe or assist in my care under the direction of my practitioner and other staff members.
4. **Photographs/Video/Voice Recordings:** I understand that photographs, video and/or voice recordings (the "Recordings") may be taken of me and used for medical purposes such as documenting or planning my care or for quality assurance or education purposes. I understand that the photographs, videos and/or voice recordings taken to document my care are part of my medical record and those taken for other purposes are not part of my medical records. To the extent that such Recordings identify me, I understand that they shall receive the same confidentiality protections as my other health information.

I have carefully read and fully understand this consent form and have had all my questions answered.

Patient's Signature: X _____ **Date:** _____