5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

CNY Obstetrics & Gynecology

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

New Patient Information

Patient Demographics:

Last name________________________________ First name___________________________________ Middle Initial______

Social Security_______________________ Date of Birth_________________________

Primary Phone___________________________________ Alt Phone#_____________________________________

Street Address____

City_____________________________________ State _________Zip _______________________

Email Address____

Primary Care Physician____ Phone #____________________________

Pharmacy ____Phone #____________________________

Employer____

Release of information to Relative/ Friend

The following named person(s) may have access to all information including medical, billing, appointment information, and emergency basis from CNY Obstetrics and Gynecology regarding my care unless otherwise indicated below.

Name ____Relationship ____

DOB ____Phone # ____

Name ____Relationship ____

DOB ____Phone # ____

Name ____Relationship ____

DOB ____Phone # ____

Emergency Contact: ______________________________________ Relationship to patient_______________________________

Phone: Cell______________________ Home ______________________ Work__________________________

* I give CNY Obstetrics and Gynecology permission to send appointment information to my email above as well as text reminders to cell number provided

_______________________________________ _______________________________________

Patient name (Printed) Date

_______________________________________ _______________________________________

Patient Signature Office staff witness

5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

CNY Obstetrics & Gynecology

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

Blood Transfusion

A blood transfusion is when your doctor gives you blood through an IV line. A blood transfusion is used to replace red blood cells. Red blood cells are the cells in your body that carry oxygen to your organs. The blood transfusion can be given through an IV line in your arm, leg, or in your neck. There are many reason to give a blood transfusion such as if you have had surgery and you have lost blood during the surgery, if your red blood cells are being destroyed by your body, if your red blood cells are not being properly produced by your body or if you have certain medical diseases such as sickle cell disease or any chronic disease that may make it difficult for your body to make red blood cells.

Preparation: Your doctor may draw blood from you to determine what type of blood you should receive. Also, your doctor may need to know how much blood to give you. Once the specific type of blood for you is identified and the amount needed, the area where they will give you the transfusion is washed with antiseptic to kill any germs. You will most likely be in a bed of a chair while you receive the transfusion.

Procedure: Once the IV is started, the blood will be given slowly. The whole procedure will take about four hours for each pint of blood transfused. Under certain situations, your doctor may need to give the transfusion more quickly. There may be a little burning sensation in the IV as you receive the transfusion.

Post Procedure: After the completion of the transfusion, the IV will be removed, if necessary. You will be watched closely to make sure that you tolerated it well. You will be monitored closely to see if you develop any reaction to the transfused blood. After your doctor is sure that you tolerated it well, you may be allowed to resume your normal activity. Your doctor may need to draw blood a couple hours after the procedure to see if you may need more blood.

Possible complications of Procedure: All procedures, regardless of complexity or time, can be associated with unforeseen problems. They will be immediate or delayed in presentation. We would like to have a list so that you may ask questions if you are still concerned. These complications include but are not limited to:

- Hepatitis B and C transmission: Hepatitis B and C are viral illnesses that affect your liver. These conditions can lead to permanent liver failure and death. The risk of getting hepatitis B with one unit of blood transfused is one in 60,000, while the risk of getting hepatitis C with one unit of blood transfused is one in 100,000.
- HIV transmission: HIV is a disease that attacks your immune system. Currently, HIV is treatable with medications, but it is not curable and it is fatal. The risk of getting HIV with on unit of blood transfused is one in 720,000.
- Bacterial contamination: The risk of the blood being contaminated with bacteria is approximately one in 500,000.

5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

CNY Obstetrics & Gynecology

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

- Fatal hemolytic transfusion reaction and fatal acute lung injury: A fatal hemolytic reaction is like an allergic reaction to blood that is transfused and leads to death. The risk of this
- happening is one in 500,000. A fatal lung injury is like an allergic reaction in your lungs from being transfused that leads to death. The risk of this occurring is approximately one in 3,000,000.

Expectations of Outcome: With a blood transfusion, you should expect for your red blood counts to increase because of the transfused red blood cells given in the transfusion. This may improve some symptoms of your low red blood cells such as dizziness and lightheadedness. Although this effect may be long lasting, if you have a medical condition where you are not producing red blood cells or your body is destroying them, the effect may last for only a short while.

In order to best treat you in a life threatening emergency where blood and blood products would/ could save your life we ask you to consent to receiving such in an emergency before we can engage with you in the care process.

Patient: ___________________________________

Patient Signature: _________________________________

Date: ______________________________

Witness: _______________________________

5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

CNY Obstetrics & Gynecology

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

Financial Policy

_______________________________ ___________________
Patient Name *Date of Birth*

The providers at CNY Obstetrics and Gynecology are here to serve your healthcare needs and are dedicated to providing you the best care possible. The intent of this policy is to clarify the role of the patient and the provider regarding billing issues. We ask that you carefully read and initial after reading each policy regardless if applicable.

Our relationship is with you, the patient, not your insurance company. Care will be administered to you based on medical necessity, not according to what is covered under your health insurance policy. Due to there being numerous insurance companies and many product lines, it is the patient's responsibility to know the benefits/ coverage and requirements of their health insurance plan. Any questions regarding coverage and/or payments of claims should be addressed directly with your insurance company. This can be an overwhelming process so at any time, you need help, we would be glad to assist you, but ultimately it is your responsibility.

Initial __________

It is your responsibility to inform staff of all insurance changes. You will be expected to present your current insurance information at *each* visit. If you have changed insurances, you must provide a copy of your new card. *If you have lost coverage, you will need to notify staff immediately*.

Initial __________

In the event you lose your insurance, you must notify the office immediately. Our office does NOT participate with Medicaid. In the event you lose your insurance you will be responsible to pay out of pocket at time of visit for an services rendered the day of your appointment. Our Obstetrical patients will pay for delivery fee's ahead of time. You will need to seek a Medicaid product the office participates with within 30 days of losing coverage or you will be asked to transfer you care to a different practice.

5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

CNY Obstetrics & Gynecology

Although we do not participate with Medicaid we do participate with the following Medicaid Managed Care Plans.

Fidelis
Total Care
United Healthcare Community Plan

If you have Medicaid as a secondary insurance, you will be responsible for any balance not covered by your primary insurance company.

Initial ________

The practice accepts Cash, or Credit as forms of payment.

Initial ________

According to your insurance plan, you are responsible for ANY and ALL copayments, coinsurances, and deductibles. All current and prior patient balances including coinsurance and deductibles are due at time of service. Service will not be performed unless payment is received. *Copays are due at time of service. You may be asked to reschedule you appointment if this is not paid at check in.*

Initial ________

We understand that circumstances arise and an appointment may need to be cancelled or rescheduled, however a *$25.00* fee will be applied to your account in the event of a No Showed appointment. A 48-hour notice is required for any Surgery/ Procedure cancellation. A *$100.00* fee will be applied to your account in the event of a No Show for a Surgery/ Procedure.

Initial _______

If your visit includes lab tests, anesthesia, biopsies, pap smears or cultures you may receive a separate bill from the company performing these services. If you receive medical care during a hospital inpatient or outpatient encounter, you may receive separate bills from the hospital, the anesthesia department and other healthcare providers involved in your care. *If you need to have your labs sent to a specific laboratory, please notify our office before any testing is performed.*

Initial __________

A well women exam occurs annually and screens for various illnesses and diseases. This is considered preventative medicine. A problem visit is one where the patient has a

5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

CNY Obstetrics & Gynecology

specific concern, symptom, or complaint. We will submit claims based on the services rendered. Depending on your insurance coverage, some or all of the cost may be billed to the patient if both a Well Women's exam and a problem visit are completed at the same appointment. We recommend you contact your insurance prior to each visit and inquire about the type of benefits you have. Once we have submitted a claim to your insurance, the office will not change the coding in order to circumvent an insurance denial as this may be considered insurance fraud.

As a courtesy to our patient's we check surgical benefits prior to services being rendered. Again, this is a courtesy and we advise you to check your insurance coverage/ benefits as well.

*Initial*__________

Accounts that are delinquent for more than 90 days without a payment agreement in place may accrue interest charges and face being sent to a collection agency.

Any balance over 120 days with no agreement in place will be sent to a collection agency and you will face discharge from the practice.

*Initial*_________

I, _________________________, have read and understand this document and understand my financial obligations to CNY Obstetrics and Gynecology. I agree to all terms and conditions.

Patient name____
Patient Signature______________________________________ Date_________________

5800 Heritage Landing Dr.
Suite C
East Syracuse, NY 13057
(p) 315-445-2701
(f) 315-445-2847

CNY Obstetrics & Gynecology

Stephen Brown, MD, FACOG
Maria Gigante-Baggett, ANP
Jessica Hays, RPA-C
Kaelyn Cicco, RPA-C

Informed Consent for Telemedicine Services

Patient Name: ___________________________

DOB: _____/_____/_____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Dr. Stephen Brown, Maria Gigante-Baggett, ANP, Jessica Hays PA, and Kaelyn Cicco, PA providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to further care or treatment. I may revoke my consent orally or in writing at any time by contacting CNY Obstetrics & Gynecology at 315-445-2701. As long as this consent is in force (has not been revoked) Dr. Stephen Brown, Maria Gigante-Baggett, NP, Jessica Hays, PA, and Kaelyn Cicco, PA may provide health care services to me via telemedicine without the need for me to sign another consent form.

Patient Signature: ________________________ Date: __________
(or authorized signer)

If authorized signer
Relationship to patient: _______________________ Date: __________

I have been offered a copy of this consent form (pt's initials) ________

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:
CNY Obstetrics & Gynecology, 5800 Heritage Landing Dr, Ste C, East Syracuse, NY 13057 Fax: 315-445-2847

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: Last 3 years, including but not limited to patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records and records provided to you by other health providers.

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.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.