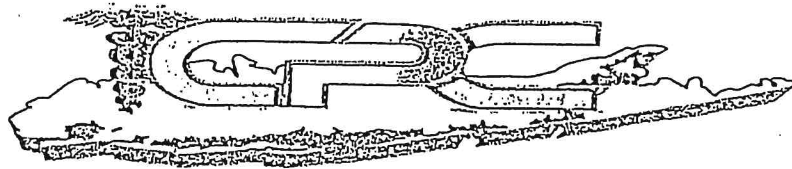


COMPLETE PRIMARY CARE
Of Long Island

Patient information

Date : ______________

Print name: (last)______________________________(first)______________________________

If patient is under the age of 18 years old, please provide parent/guardian name and email address

Parent/Guardian Name (last)____________________________(first)____________________________

Email:____ Cell phone:_______________________

Parent/Guardian Email:____________________________ Home Phone:_______________________

Date of Birth:(M)____/(D)_____/(Y)_______ Age:________ Sex ☐ Male ☐Female ☐other

Marital status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widow

Race: ☐African American ☐American Indian/Alaska Native ☐Asian ☐Hispanic ☐White/Non-Hispanic ☐Other

Primary Language: ☐ English ☐Spanish ☐Other: ____________________

Home Address:

Street________________________________City/State________________________ZIP:____________

EMPLOYER'S INFORMATION

Company Name____________________________________ Occupation: ________________________

Work Address:

Street________________________________City/State________________________ZIP:____________

Work phone number:____________________________ext__________

INSURANCE INFORMATION

Policy holders name:

(last)______________________________(first)____________________________DOB____/____/______

Address (if different from patient)

Street________________________________City/State________________________ZIP:____________

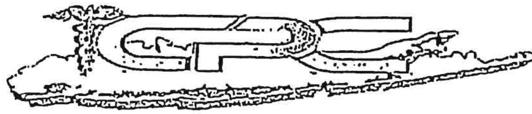
Group number________________ Policy number______________________ co-payment $__________

Patients relationship to policy holder: ☐Self ☐Spouse ☐Child ☐Other________________

Emergency contact information:

Name__________________________Relationship_________________Phone number______________

Name__________________________Relationship_________________Phone number______________



COMPLETE PRIMARY CARE
Of Long Island

Dr. Scott G. Brown, DO | Dr. Keith Leventhal, DO | Vincent Polo, PA-C | Joseph Accetta, PA-C

2374 Jerusalem Avenue
North Bellmore, NY 11710

P: 516-409-8311
F: 516-409-8313

Patient Consent Form

In response to misuse of personal health information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help ensure that PHI is kept private. This rule was also established in order to provide a standard for health care providers to obtain the consent of their patients for the use and disclosure of medical information about the patient in order to carry out treatments, payments or other healthcare care operations.

We want you to know that we respect the privacy of your medical records and will take all reasonable measures to ensure and protect your privacy. When necessary, we will provide the minimum necessary information only to those who we believe need your PHI in order to provide you with the medical care that is most convenient for you.

We support your full access to all your personal medical records. You should bear in mind that we may have an indirect treatment relationship with you that includes, among others, laboratories, pharmacies and other medical offices. As such, we may have to disclose PHI for treatment, payment and / or other health care operations purposes. These external entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse consent for the use of the disclosure of your PHI. This refusal must be made in writing. If you give your consent to disclose your PHI, by signing this document, in the future you may request to refuse future disclosure of your PHI. This refusal must be made in writing. However, you cannot revoke actions that have already been taken and that have been based on this or a previously signed consent. You have received a copy of our Patient Privacy Policy.

You have the right to review your privacy notice, request restrictions and revoke your consent in writing after reviewing our privacy notice.

Talk to our Compliance Officer if you have any objection to this consent.

____
Signature of Patient/ Legal Guardian

____
Print Patient's Name

____
Print name of Legal Guardian (if applicable)

COMPLETE PRIMARY CARE
Of Long Island

Dr. Scott G. Brown, DO Dr. Keith S. Leventhal, DO Vincent J. Polo, PA-C
Gina L. Pontrelli, PA-C Julia N. Laibach, PA-C

2374 Jerusalem Avenue
North Bellmore, NY 11710

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Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- ✓ Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- ✓ The practice reserves the right to change the privacy policy as allowed by law.
- ✓ The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- ✓ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- ✓ The practice may condition receipt of treatment upon execution of this consent.

May we phone, e-mail, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please list the members allowed:

Name:____________________ Relation:________________ Phone Number:_______________

Name:____________________ Relation:________________ Phone Number:_______________

This consent was signed by:__________________________
PRINT NAME

Signature: ____________________________________ Date:____________

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

New York State Department of Health

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 all Complete Primary Care of Long Island to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get healthcare can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit Healthix's website at www.healthix.org.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health 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 Complete Primary Care of Long Island to access ALL of my electronic health information through Healthix to provide healthcare.
☐ 2. I DENY CONSENT for Complete Primary Care of Long Island to access ALL of my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health record through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions 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)