PHOENIX
HEALTH & WELLNESS

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____
(First) (Last)

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female
(Month) (Day) (Year)

Address: _____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

Home #: _____ Cell #: _____

E-mail: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other: _____

Contact Method: ☐ Home ☐ Mobile ☐ E-mail Language: ☐ English ☐ Spanish ☐ Other: _____

Employer Name: _____

Employer Address: _____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____ Phone #: _____

PRIMARY INSURANCE

Insurance Name: _____

ID #: _____

Policy Holder's Name: _____

D.O.B: _____/_____/_____
(Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

SECONDARY INSURANCE (If Applicable)

Insurance Name: _____

ID #: _____

Policy Holder's Name: _____

D.O.B: _____/_____/_____
(Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

PHARMACY

Pharmacy Name: _____ Phone #: _____

Address: _____

New Patient Medical History

PLEASE BRIEFLY STATE IN THE BOX BELOW THE REASON FOR YOUR VISIT

PAST MEDICAL HISTORY

Condition / Disease	Year Began
☐ Hypertension	
☐ High Cholesterol	
☐ Hyper / Hypothyroidism	
☐ COPD, Emphysema, or Asthma	
☐ Diabetes	
☐ GERD	
☐ Depression or Anxiety	
☐ ADD or ADHD	
☐ Heart Conditions	
☐ Other(s):	

PAST SURGICAL PROCEDURES/HOSPITALIZATIONS/SERIOUS INJURIES

Operation / Hospitalization / Injury	Month / Year

FAMILY HISTORY

Relative	**Living / Deceased**	**Current age or Age at Death**	**Cause of Death**	**Health Problems**
Father:				
Mother:				
Brother(s):				
Sister(s):				
Children(s):				

MEDICATION / FOOD ALLERGIES OR INTOLERANCES
LIST BELOW MEDICATIONS OR FOODS CAUSING AN ALLERGIC REACTION (I.E., RASH, SWELLING) OR INTOLERANCE (I.E., NAUSEA)

Medication / Food	Reaction

CURRENT MEDICATIONS

Medication Name	Dosage

VACCINATIONS

	Date (Month / Year)
Tetanus (Tdap)	
Influenza	
Pneumovax (Pneumonia)	
Zostavax (Shingles)	

HEALTH MAINTENANCE

Test Performed	Date (Month / Year)	Please Check Yes or No
Lipid (Cholesterol)		Abnormal? ☐ Yes ☐ No
Colonoscopy		Abnormal? ☐ Yes ☐ No
Mammography		Abnormal? ☐ Yes ☐ No
Pap Smear		Abnormal? ☐ Yes ☐ No
Bone Density		Abnormal? ☐ Yes ☐ No
Eye Exam		

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No	Number of drinks?
Do you currently smoke? ☐ Yes ☐ No	If yes, how many packs per day?
Are you a former smoker? ☐ Yes ☐ No	If yes, what year did you quit?
Do you exercise? ☐ Yes ☐ No	Duration and Frequency?

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have read a copy of **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's compliance team.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

CONSENT TO TREATMENT

I hereby request and consent to diagnostic, therapeutic procedures and medical treatment by **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** as determined necessary in the professional medical judgment of my treating physician, including but not limited to electrocardiograms, blood tests, and administration of medications and vaccinations and obtaining e-script history, as applicable. I am aware that the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantee as to the outcome of any procedures, treatments or examinations have been made to me.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION TO SECOND PARTY

By signing below, I hereby give permission to **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____ Phone #: _____

Name of Individual _____ Relationship to patient _____ Phone #: _____

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-pays, any services that is not covered by your insurance plan, and any service that your insurance company has determined not be "medically necessary".

I have read and understand this information. I understand that my insurance company may deny coverage and request that **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services. Without requiring payment at the time of service based on such reliance.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I authorize insurance payments to be made directly to **South Shore Family Practice** for services rendered. I understand that I am responsible for any and all balances not covered by my insurance carrier.

I hereby authorize **South Shore Family Practice** to release medical or incidental information that may be necessary for medical care or processing of insurance claims.

I verify that all information provided regarding my insurance is accurate. I will notify **South Shore Family Practice** office staff if any changes are made to my insurance. I authorize release of records upon request. A photocopy of these assignments shall be valid as the original.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

Narcotic Agreement

** Please read this page **ENTIRELY** and **CAREFULLY**. **

PHOENIX HEALTH & WELLNESS is issuing you a narcotic prescription and with initialing after each statement and signing at the bottom, you are agreeing to the following terms and conditions:

_____ I will keep (and be on time for) all my scheduled appointments with the physician treating me.

_____ If the medicine is lost or stolen, I understand it will **NOT** be replaced until my next appointment.

_____ All narcotics **WILL NOT** be issued more than one month at a time or at the discretion of the physician.

_____ Prescriptions will not be sent to my pharmacy sooner than my prescribed time, **NO EXCEPTIONS**.

_____ No narcotics are to be issued at any other physicians' office while under my care with narcotic treatment, unless my physician is aware I am being treated by another physician for a separate condition.

_____ The day of the appointment I will be asked to do a drug screening via urine and/or swab.

_____ I will be asked to come in the office to submit random drug screenings for compliance.

_____ If the medications that have been prescribed to me are not in my system, or illicit drugs (heroin, cocaine, etc.) are detected, it will result in immediate discharge from the practice and no narcotic prescriptions will be issued to me.

Patient Name: _____ D.O.B: _____

Patient Signature: X_____ Date: _____

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 **PHOENIX HEALTH & WELLNESS** 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 health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization 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 Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

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 **PHOENIX HEALTH & WELLNESS** to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for **PHOENIX HEALTH & WELLNESS** to access 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 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 healthcare 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
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test

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 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, call **PHOENIX HEALTH & WELLNESS** at (631) 647-4567; or visit Healthix's website: www.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, death or until such time as Healthix ceases operation. 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.