30 Reade Place
Poughkeepsie, NY 12601
Ph: 845-214-1096
Fax: 845-232-5256

NESHEIWAT MEDICAL PRACTICE
WHERE PASSION MEETS CARE
Estd. 2009

1989 Route 52, Suite 2
Hopewell Junction, NY 12533
Ph: 845-765-2404
Fax: 845-765-2406

Welcome to Nesheiwat Medical Practice!

Thank you for selecting your Primary Care Physician with Nesheiwat Medical Practice.

An appointment has been reserved for you on: _____ with

Dr. _____.

Before your first visit:

• Call your health insurance company and list Dr. Nesheiwat as your new Primary Care Physician (PCP). Please give them his NPI # 1194809145. Some insurance companies require this.

• A medical record release has been enclosed for your convenience, or, if you prefer, you may contact your current primary care physician's office directly to request that your records be transferred to our office.

• Please complete the enclosed New Patient Health History and sign the enclosed Financial, Cancellation, and Medication Policy.

Please Note: Failure to complete the New Patient Health History forms and sign the policy forms will result in the automatic cancellation of your new patient appointment. We thank you in advance for your cooperation regarding this policy.

On your first visit, please bring:

1. Your current insurance card and a government-issued photo ID.

2. Your co-pay/co-insurance or deposit (if applicable). We accept cash, check, Visa, MasterCard, Discover, and American Express.

3. All medication bottles

4. Please arrive 20 minutes prior to your scheduled appointment time. If you need to cancel your appointment for any reason, please allow a minimum of 24 hours' notice.

WELCOME!

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Our Policy Follow-Up Appointments:

- If you are more than 15 minutes late for your scheduled appointment, we reserve the right to reschedule your appointment to another day. If you are excessively late for 3 scheduled appointments, or NO SHOW for 2 appointments, we reserve the right to discharge you from our practice.
- All co-payments and co-insurances are due in full at the time of your visit.
- Same day appointments are available for urgent issues.
- We provide equal appointment availability for all of our established patients regardless of insurance status or type of insurance.

Prescriptions:

- NO prescriptions (new or refills) can be written for new patients until you have been in our office to establish care.
- Future refill requests for routine/maintenance medications can be requested online at NesheiwatMedicalPractice.com or by simply calling and requesting a refill from our staff.
- Refills are authorized by your provider (or covering provider) within 1-2 business days. Please do not wait until you are out of medication to call us.
- Prescriptions for controlled substances may not be filled at your first new patient appointment. This will be done at the discretion of the Provider. If you have any questions, please feel free to contact the office.

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Patient Financial Policy

Thank you for choosing Nesheiwat Medical Practice for your medical care. We are dedicated to providing the best possible care for you. We offer the following information to help you understand our financial policy and to aid you in planning for payment.

Nesheiwat Medical Practice believes that financial difficulties should not prevent you from receiving the medical care that you need, when you need it. Please contact our Billing Department to discuss any concerns. Payment plans are available if needed.

Our Billing Department may be reached at: 212-536-7667.

Insurance Verification and Co-payments

You are expected to present an insurance card at each visit. We will bill your primary insurance company as a courtesy. Failure to provide complete insurance information to us may result in your responsibility to pay the entire bill. All co-payments, deductibles and past due balances are due at the time of service. Failure to pay your co-pay at time of service will result in an additional $10.00 fee. All payments are expected to be made in U.S. dollars. Nesheiwat Medical Practice accepts cash, personal check, and credit card (Visa, MasterCard, American Express, Discover). There is a $35.00 fee for returned checks.

It is your responsibility to be aware of the details of your insurance coverage, including any requirements for referrals or pre-authorization. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage when scheduling an appointment. In addition, please ensure that you have designated a Nesheiwat Medical Practice physician as your Primary Care Physician (PCP) if your insurance company requires you to designate a PCP.

Self-Pay Accounts

Patients without insurance coverage, patients without an insurance card on file with the practice, or whose insurance is not accepted by the practice have "self-pay" accounts.

This includes patients who have applied for Medicaid who do not yet have a valid Medicaid number. Liability cases are considered self-pay accounts unless a case number is provided. Nesheiwat Medical Practice does not accept attorney letters or contingency payments. If there is a discrepancy with the insurance information you provided to Nesheiwat Medical Practice, you will be considered self-pay until otherwise proven. If you are a self-pay patient, you will be expected to pay for services before you are seen. Additional fees may be applied. Labs and outside imaging will be billed separately.

High Deductible Plans (Health Savings Accounts or Heath Reimbursement Accounts)

If your insurance is a High Deductible Plan you may be required to make a down payment of at least $75.00 at the time of service. If the total cost of services rendered is more than down payment you will be billed for the remaining amount. If the cost of your visit is less than the down payment we will send you a refund of the difference within 60 days if the deposit causes your overall patient account to have a credit balance.

No-Fault/Workers Compensation

You are responsible for providing our office with all information required to properly submit charges on your behalf before you can be seen(name of insurer, address, claim number, date of injury, etc.). Without this information you will be responsible for payment for the full cost of your visit(s). If you have private insurance with which we participate and you obtain any necessary referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

Medicare

We are "participating physicians" with Medicare. This means that we must accept Medicare's allowed charge for services rendered. Traditional Medicare will pay 80% of the approved amount. You are responsible for the remaining 20% plus any deductible that your plan may require. This payment is due at the time of service. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance to your secondary insurance after Medicare has paid. Please remember that although we accept assignments for Medicare,

the patient, by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

Responsibility for Minors

The parent/guardian who holds the insurance policy for the child is considered the guarantor for the child and is responsible for payment regardless of personal circumstances.

No-Show/Cancellation Fee

A fee of $25.00 may be charged for any appointments missed or not canceled at least 24 hours before the scheduled visit. It is your responsibility to notify the office when an appointment needs to be canceled or rescheduled.

Form Completion Fee

Please allow at least one week for forms to be completed. Some forms require an office visit in order to complete the forms. You must have been seen within the last 30 days for any forms to be completed.

Late Fees

Payment is due within 30 days from the date of the initial billing statement. A $10.00 late fee will be assessed on each statement generated after the first statement until the outstanding balance is paid. Please contact the billing department if you are unable to pay your balance so a payment plan can be set up, and late fees may be avoided.

Referrals and Authorizations

Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Past Due Accounts and Failure to Follow Payment Arrangements

Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made within 120 days, your account will be turned over to a collection agency.

Financial Difficulties

We encourage our patients to discuss any unexpected financial circumstances with our Billing Department. We realize that financial difficulties may sometimes arise, and the Billing Department will work with you to make a payment plan under these circumstances.

Release of Information

By signing below, you authorize the release of necessary medical information to Nesheiwat Medical Practice for the purpose of processing any claims. You also authorize Nesheiwat Medical Practice to release and obtain any information pertinent to your case for purposes of payment. Assignment of Payment By signing below, you authorize payment directly to Nesheiwat Medical Practice for the surgical and/or medical benefits, if any, otherwise payable to you under the terms of your insurance. By signing below, you acknowledge that you have read, understand, and will cooperate with the financial policy of Nesheiwat Medical Practice.

_____ _____

Patient Name (Printed) Patient Date of Birth

_____ _____

Patient Signature or Responsible Party if Minor Date

PATIENT NAME:	DATE OF BIRTH:

PATIENT DEMOGRAPHICS

Street Address:

City: State: Zip:

Social Security #:	
Preferred Phone #:	Alternate Phone #:

Email Address:

Primary Language: If primary language is not English: Do you speak English? Y / N

Previous Primary Physician:

RACE	ETHNICITY	SEX	GENDER IDENTIFICATION
☐ Black or African American ☐ American Indian/Eskimo ☐ Asian ☐ Caucasian ☐ American Indian, Alaska Native ☐ Native Hawaiian/Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic nor Latino	☐ Male ☐ Female ☐ Male-to-Female Transgender ☐ Female-to-Male Transgender	☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to say

EMERGENCY CONTACT Note: If under 18, name of Responsible Parent/Guardian.

Name:	Relationship to you:
Primary Phone #:	Secondary Phone #:

INSURANCE

Primary Insurance Name: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Member ID. _____ Group #: _____

Secondary Insurance Name: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Member ID: _____ Group #: _____

Do you use Medicaid transportation to travel to your medical appointments? Y / N

PHARMACY INFO

Do you use a **Mail Order Pharmacy?** Y / N If Yes:	**Local Pharmacy**
Name: Address: Phone #:	Name: Address: Phone #:

SIGNATURE

_____ _____

Signature **Date**

Your Name, if completed by someone other than the patient: Relationship:

PATIENT NAME:	DATE OF BIRTH:

ALLERGIES *Include drugs, foods, chemicals, insects, etc. IF NO KNOWN ALLERGIES, PLEASE CHECK "NONE".*

ITEM	TYPE OF REACTION
☐ NONE	

MEDICATIONS Include all current medications including prescription and over-the-counter herbal/vitamins/supplements. IF NOT ON ANY MEDICATIONS, PLEASE CHECK "NONE".

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT TAKEN?	REASON FOR MEDICATION	PROVIDER PRESCRIBING THIS MEDICATION
Example: Aspirin	81 MG	Daily, Twice, Bedtime, etc.	Stroke Prevention	Dr. John Doe
☐ NONE				

Please take time to provide the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs. **Please address every section.**

PATIENT NAME:	DATE OF BIRTH: / /	PREFERRED PRONOUNS: ☐ he/him ☐ she/her ☐ they/them
EMAIL ADDRESS:		

MEDICAL HISTORY

Please fill in date of onset for any conditions you have had in the past, and check box for any conditions that you still have.

Condition	Date of Onset	Condition	Date of Onset	Condition	Date of Onset
☐ NONE		☐ Hiatal hernia		☐ Arthritis	
☐ Migraine headaches		☐ Chronic heartburn		☐ Gout	
☐ Seizures or convulsions		☐ Stomach ulcer		☐ Broken bones (Type:)	
☐ Stroke		☐ Duodenal ulcer			
☐ Glaucoma		☐ Hepatitis		☐ Varicose veins	
☐ Cataracts:		☐ Cirrhosis		☐ Phlebitis or blood clots	
Circle: Left Right Both		☐ Gall stones		☐ Bleeding problems	
☐ Recurrent ear infections		☐ Colon or bowel trouble		☐ Sickle cell	
☐ Hay fever/allergic nose		☐ Dysentery or severe diarrhea		Circle: Trait Disease	
☐ Chronic sinusitis				☐ Anemia	
☐ Asthma		☐ Rectal trouble		☐ Cancer (Type:)	
☐ Chronic bronchitis		☐ Chicken pox			
☐ Emphysema		☐ Mumps		☐ HIV infection/AIDS	
☐ Tuberculosis		☐ Measles		☐ Gonorrhea	
☐ Overactive thyroid		☐ Polio		☐ Syphilis	
☐ Underactive thyroid		☐ Diabetes		☐ Genital herpes infection	
☐ Goiter		☐ Breast lump(s)		☐ Anxiety	
☐ Heart murmur		☐ Skin problems		☐ Depression	
☐ Heart attack		☐ Hemorrhoids		☐ Emotional problems	
☐ Angina		☐ Urinary incontinence		☐ Nervous breakdown	
☐ Enlarged heart		☐ Recurrent urinary infections		Women:	
☐ Rheumatic fever				☐ Menstrual difficulties	
☐ High blood pressure		☐ Kidney stones		☐ Abnormal PAP	
Men:		☐ Other kidney disease		☐ Ovarian cyst(s)	
☐ Prostate trouble		☐ Other:		☐ Gestational diabetes	
☐ Erectile Dysfunction		☐ Other:		# of pregnancies:	
				# of births:	

PAST MEDICAL HISTORY *Please list any Surgeries, Procedures, Hospitalizations NOT ALREADY NOTED ABOVE.*

Procedure/Reason/Diagnosis	Date	Procedure/Reason/Diagnosis	Date
☐ NONE		5.	
1.		6.	
2.		7.	
3.		8.	
4.		Please use a separate sheet of paper to list any others.	

PATIENT NAME:	DATE OF BIRTH:

IMMEDIATE FAMILY HISTORY *Please complete the following on your biological ("blood") relatives.*

Please write in family member's name and check box if also a patient at this practice.	Living	Deceased	Age	Sex	Chronic Condition(s) - If deceased, Cause of Death
Father: ☐	☐	☐		--	
Mother: ☐	☐	☐		--	
Brothers or Sisters: ☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
Children: ☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	

FAMILY HISTORY

Please complete the following on your biological relatives NOT COVERED ABOVE. Please note which relatives are affected; if extended family, such as aunt/cousin/grandparent, please note whether on maternal (mother's) or paternal (father's) side.

Condition	Relation	Condition	Relation	Condition	Relation
☐ Stroke	_____	☐ Bleeding problems	_____	☐ Diabetes	_____
☐ Heart trouble	_____	(Type: _____)		☐ Birth defects	_____
(Type: _____)		☐ Clotting disorders	_____	(Type: _____)	
☐ Early heart disease	_____	☐ Cancer, including leukemia	_____	Other: Condition	Relation
(males under 55, females under 65)		(Type: _____)		☐ _____	_____
				☐ _____	_____

YOUR CARE TEAM *Please list any specialists or other health care providers involved in your care, including OB/GYN, oxygen companies, visiting nurse agencies, etc.*

☐ NONE

Location seen at: _____

Location seen at: _____

Location seen at: _____

Location seen at: _____

Location seen at: _____

PATIENT NAME:	DATE OF BIRTH:

SOCIAL/PERSONAL HISTORY *Please complete the following information about yourself.*

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Stay-at-home

Current Occupation: _____

Have you ever worked in a job where you were exposed to hazardous environment or chemicals? Y / N

If Yes, when and what: _____

Highest Education Completed:

☐ Grade: _____ ☐ High School ☐ College: _____ years; Degree/Major: _____

☐ Post-graduate: _____

Marital Status: ☐ Single ☐ Married (Date: _____) ☐ Separated (Date: _____)

☐ Divorced (Date: _____) ☐ Widowed (Date: _____) Married: _____ time(s)

Personal Habits: *(check all that apply)*

☐ Never used nicotine

☐ Currently nicotine use: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco ☐ e-Cigarettes

Amount/Day: _____ Years: _____

☐ Former nicotine use: Type/Amount/Day: _____ Years: _____ Quit Date: _____

☐ Exposed to second-hand smoke/nicotine: Amount/Day: _____ Years: _____

Consume alcohol: Y / N Type: _____ Amount/Day: _____

Use recreational drugs or any problems misusing prescription medications: Y / N

If Yes, type: _____ Frequency: _____

Consume caffeine: Y / N If Yes, beverage type: _____

Amount/Day: _____

Exercise regularly: Y / N If Yes, activity type(s): _____

Frequency: _____

Do you wear a seatbelt? Always / Occasionally / Never

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

Do you talk/text on phone while driving? Y / N

Do you have a smoke detector? Y / N

Do you have a carbon monoxide detector? Y / N

Do you have any unsecured guns in the home? Y / N

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

Please describe your comfort level in understanding concepts and care requirements related to managing your health: ☐ No concerns ☐ Occasional difficulty, with guidance/direction feel comfortable ☐ Frequent difficulty, require extra assistance

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? _____

Do you have a caregiver? Y / N If Yes, whom: _____

Are you a caregiver for an adult? Y / N If Yes, for whom: _____

Do you have any pets? Y / N If Yes, type/how many: _____

Do you have a good support network of family/friends? Y / N If No, please explain:

_____

PATIENT NAME:	DATE OF BIRTH:

Do you have concerns about meeting basic needs for shelter, food, medication or clothing? Y / N If Yes, would you like information on resources that may be of assistance to you? Y / N

Do you have any communication needs due to hearing, seeing or other issues such as memory or difficulty understanding or reading? Y / N If Yes, please explain: _____

Do you have any cultural, spiritual or personal beliefs that affect your health care needs? Y / N If Yes, please explain:

_____

Do you have a health care proxy? Y / N / Not Sure If Yes, please ensure this practice has a copy for your records.

Do you have advanced care directives? Y / N / Not Sure If Yes, please ensure this practice has a copy for your records.

Would you like to discuss planning Advance Directives at your visit? Y / N

GOAL SETTING *Please complete the following information about yourself.*

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren) _____

_____

How do you plan to accomplish these goals? _____

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractions, genetics)

_____

_____

IMMUNIZATIONS & PREVENTIVE SERVICES *Check all that you have had and PROVIDE DATE done.*

PLEASE NOTE: All patients under 18 must have vaccine records either attached or transferred by previous provider

	DATE/YEAR
☐ Flu vaccine	_____
☐ HPV/Gardasil	_____
☐ Tetanus	_____
☐ Tdap	_____
☐ Pneumonia vaccine	_____
☐ Prevnar	_____
☐ Zoster Vaccine	_____
☐ Hep B series	_____
☐ Hep A	_____
☐ MMR	_____
☐ Other: _____	

	DATE/YEAR
☐ Dental exam	_____
☐ Eye exam	_____
☐ GC/Chlamydia screen	_____
☐ Hearing test	_____
☐ HIV testing	_____
☐ TB skin test	_____
☐ Other _____	
☐ Last Physical/Annual Exam: _____	

*If you are not certain of date, please contact your insurer. If you have already had a physical/annual exam this year, your insurance may not cover a second well visit and this could leave you responsible for payment.

	DATE/YEAR
☐ PAP smear	_____
☐ Mammogram	_____
Where: _____	
☐ Bone density test	_____
☐ PSA	_____
☐ Colonoscopy	_____
Where: _____	
☐ Abdominal Aortic Aneurysm Screening	_____
Where: _____	
☐ Other: _____	
☐ NONE	

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.

QuestQuanum™

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:
Nesheiwat Medical Practice 30 Reade Place Poughkeepsie NY 12601 P-845-232-5256 F-845-232-5256

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: _____

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:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **Cont of Care**	
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.**