Patient Information Form

Date: ________________

Patient Name: ___________________________________**DOB**____________________ **Gender:** ☐M / ☐F
Street Address: __________________________ **City**: _______________ **State**: ______ **Zip:** ___________
Email Address: ____ **Phone**: (**Home**) ___________________
(**Work**)_______________________________________ (**Cell**) _____________________________________

Please indicate if it is okay to leave a confidential voicemail that may have test results, prescription information or any other medical information. ☐ YES ☐ NO

The best way to contact you? Please select all that apply:

☐Mail ☐Text ☐Phone ☐Email

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Language:** _________________________

Ethnicity: ______________________ **Race:** ☐Asian ☐African American ☐White ☐American Indian ☐Other

Employer: _____________________________________ **Occupation**: ________________________________

In case of emergency, contact
Name: _____________________________ **Relation:** ___________ **Contact #:** _________________________

Primary Insurance Information:

Subscriber's Name	Identification Number	Group Policy Number	Effective Date
			____/____/____

Name of Insurance Company/ Administrator	Address	City	State	Zip code

Secondary Insurance Information:

Subscriber's Name	Identification Number	Group Policy Number	Effective Date
			____/____/____

Name of Insurance Company/ Administrator	Address	City	State	Zip code

Insurance Plan Type: ☐ PPO ☐ EPO ☐ MC ☐ HMO ☐ Private ☐ Worker's Comp

☐ If your insurance plan is EPO, MC or HMO It may require a prior authorization.

MEDICATIONS: Please provide us with any medications you are currently taking including prescription and non-prescription medicines, vitamins, home remedies, birth control pills, or herbs. ☐ I take no medications

Medication	Dose	Times / Day	Medication	Dose	Times / Day

PERSONAL MEDICAL HISTORY:

Have *you* ever had any of the following problems? If so, please provide approximate year:

☐ Cancer ______ ☐ Heart attack ______ ☐Blood transfusion ______ ☐ Stroke ☐Seizure ______

Do *you* have any of the following problems? ☐ Check all that apply.

☐ Asthma	☐ Chest pain	☐ Hiatal hernia	☐ Seizures
☐ Anemia	☐ Cancer	☐ High Cholesterol	☐ Skin/Skinderm
☐ Allergies	☐ Diabetes	☐ Headache/Migraines	☐ Stomach/bowel
☐ Arthritis/joint pains	☐ Dizziness/Vertigo	☐ Headache/Migraines	☐ Swollen legs
☐ Black outs	☐ Emphysema/COPD	☐ High blood pressure	☐ Thyroid disorder
☐ Breathing trouble	☐ Eye/Ear/Nose/Throat disorders	☐ Hepatitis/Liver failure	☐ Other
☐ Back pain	☐ Heartburn/Acid reflux	☐ Kidney disorder/failure	
☐ Blood/bleeding disorder	☐ Heart Attack/ Heart problems	☐ Meningitis	

How did you hear about us? ____
Please briefly tell us your reason for visiting us today: ____

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS: ☐I am not allergic to any medications.

MEDICATION/AGENT	REACTION/SIDE EFFECTS

SURGICAL HISTORY (Please list all prior operations and dates): ☐ I have had no prior surgery.
____ Date: _______________ **SOCIAL HISTORY:**

Please check one: ☐ I have never smoked. ☐ I have smoked, but rarely. When was the last time? ___________
☐ I have quit smoking. Quit on ___________ ☐ I currently smoke ____ packs /_____ cigarettes a day. ☐ I drink ☐ Drinks per day/week _______________ ☐ Illicit drug use _____________________

PREVENTATIVE CARE*:*

Last Physical: _________________________________ Last Colonoscopy: ____________________________
Last time blood was drawn: _____________________ Influenza vaccine: ____________________________
Last Dentist visit: ______________________________ Pneumonia vaccine: ___________________________ Last Ophthalmologist visit: _____________________ A health care proxy? _________________________

Females:

Last menstrual period (LMP): __________________
Last PAP smear: _______________________________
Last Breast exam: _____________________________
Last Bone Density (Dexa) scan: _________________
Last Mammogram: _____________________________
Are you Pregnant? _____________________________

Males:

Last prostate exam: __________________________
Last Prostate specific antigen (PSA): __________

FAMILY HISTORY:

Please indicate with a check (☐) family members who have had any of the following conditions:

Medical Conditions	MOTHER	FATHER	SISTER	BROTHER	DAUGHTER	SON	OTHER
Alcoholism							
Anemia							
Anesthesia prob.							
Arthritis							
Asthma							
Bleeding							
Cancer							
Diabetes							
Epilepsy (Seizures)							
Genetic diseases							
Glaucoma							
Heart Attack							
High Blood Pressure							
High cholesterol							
Kidney diseases							
Lupus							
Osteoporosis							
Stroke							

Thyroid disorders							
Tuberculosis							
Other:							

Assignment of Benefits

I hereby assign to **East Meadow Medical P.C.** any insurance or other third-party benefits available for health care services provided to me. I understand that **East Meadow Medical P.C** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **East Meadow Medical P.C**, I agree to forward to **East Meadow Medical P.C** all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: ____ Date: __________________

Consent to Treat

I (or my legal guardian or parent) authorize **East Meadow Medical P.C**. to provide medical care reasonable by today's standards.

Signature of Patient/Legal Guardian: ____ Date: __________________

Authorization for Release of Information

I authorize **East Meadow Medical P.C.** to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize East Meadow Medical P.C. to release all medical information to my referring physician and my primary (family) physician. I authorize East Meadow Medical P.C. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to East Meadow Medical P.C.

I agree that these provisions will remain in effect until I provide written revocation to East Meadow Medical P.C.

Signature of Patient/Legal Guardian: ____ Date: __________________

Consent to Obtain External Prescription History

I, __________________________, whose signature appears below, authorize **East Meadow Medical P.C** and Its Affiliated Providers to view my external prescription history via Electronic medical records Rx service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient ____ Date __________________

Witness____ Date __________________

Preferred Pharmacy: Please indicate which pharmacy you would like your prescriptions to be sent to.

Name of Pharmacy: ____

Address: ____

Phone #: ________________________________ Fax #: ____

Patient Portal

Please send me an email invitation to register for the patient portal. The portal can be used to request appointments, medication refill requests and nonemergent medical questions. Initial: ____________________

Patient Consent Form

East Meadow Medical P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **East Meadow Medical P.C.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **East Meadow Medical P.C.** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **East Meadow Medical P.C.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **East Meadow Medical P.C. 295 E Meadow Ave, East Meadow, NY 11554.**

With this consent, **East Meadow Medical P.C.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **East Meadow Medical P.C.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **East Meadow Medical P.C.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **East Meadow Medical P.C.** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **East Meadow Medical P.C.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **East Meadow Medical P.C.** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

________________________________ ________________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Authorization Form

East Meadow Medical P.C.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **East Meadow Medical, P.C.** to use and/or disclose certain protected health information (PHI) about me to _________________________.
This authorization permits **East Meadow Medical, P.C** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): The information will be used or disclosed for the following purpose:
(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.") The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire in one year.
The Practice will _____ will not _____ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

East Meadow Medical P.C 295 E Meadow Avenue East Meadow, NY 11554

Signed by: _______________________________ ________________________
Signature of Patient or Legal Guardian Relationship to Patient

_______________________________ ________________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Dr. Sebeen Razzaq Ahmed does not prescribe chronic controlled substances. If you are in need of a refill of these medications, you will be referred to the appropriate specialist i.e. pain management or Psychiatry.

Signed by: _______________________________ ________________________
Signature of Patient or Legal Guardian Relationship to Patient

_______________________________ ________________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Notice of Privacy Practices

Effective date: _______________

East Meadow Medical, P.C.

Notice of Privacy Practices
As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment**. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health care operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct costmanagement and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Optional **Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Optional **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Optional **Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Optional **Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
8. **Disclosures required by law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks**. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths,
   - Reporting child abuse or neglect,
   - Preventing or controlling disease, injury or disability,
   - Notifying a person regarding potential exposure to a communicable disease,
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
   - Reporting reactions to drugs or problems with products or devices,
   - Notifying individuals if a product or device they may be using has been recalled,
   - **Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,**
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health oversight activities**. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and similar proceedings**. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law enforcement**. We may release PHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
   - Concerning a death we believe has resulted from criminal conduct,
   - Regarding criminal conduct at our offices,
   - In response to a warrant, summons, court order, subpoena or similar legal process,
   - To identify/locate a suspect, material witness, fugitive or missing person,
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
5. **Optional Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Optional Organ and tissue donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Optional Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
   (A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
   (B) The research could not practicably be conducted without the waiver,
   (C) The research could not practicably be conducted without access to and use of the PHI.
8. **Serious threats to health or safety**. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military**. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates**. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' compensation**. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311,** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.** Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. **Inspection and copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a paper copy of this notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.**

7. **Right to file a complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint**. **8. Right to provide an authorization for other uses and disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **East Meadow Medical P.C., 295 E Meadow Avenue, East Meadow, NY 11554, 516-222-0311.**

Patient Name: ________________________________ Relationship to Patient: __________________________

Signature: ____________________________________ Date: __________________________

We Appreciate Your Visit at East Meadow Medical