THE WOMAN'S HEALTH PAVILION

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION:

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ (MM/DD/YYYY) SOCIAL SECURITY NUMBER: _____-_____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: __ SINGLE __ MARRIED __ PARTNER __ DIVORCED __ WIDOWED

Whom do we thank for referring you to our practice? _____

CONTACT INFORMATION:

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION:

FIRST NAME: _____ LAST NAME: _____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY CARE/ OTHER PHYSICIAN:

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____ CO-PAY_____

GROUP #: _____ SUBSCRIBER #: _____

SUBSCRIBER FIRST NAME: _____ LAST NAME: _____DOB: _____

RELATIONSHIP TO PATIENT: _____

ADDITIONAL INSURANCE:

INSURANCE COMPANY: _____ CO-PAY_____

GROUP #: _____ SUBSCRIBER #: _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

How may we contact you with medical information?

Under HIPAA, you have the right to choose how we may communicate with you. We will honor your request unless an emergency exists.

Please indicate if we may contact you with a detailed message using the following:

Your home phone: ( ) Yes ( ) No Verify number if yes: _____

Your cell phone: ( ) Yes ( ) No Verify number if yes: _____

Your work phone: ( ) Yes ( ) No Verify number if yes: _____

Your email address: ( ) Yes ( ) No Verify email if yes: _____

(please indicate "yes" or "no" for EACH)

Note that appointment reminders and recall reminders may be sent by mail, voice, text, or email, or any combination of the above to any telephone numbers and addresses provided.

*

Please specify the name of any other person(s) whom you authorize to contact our office and access your medical information on your behalf:

_____ _____

(Name of individual #1) *(Name of individual #2)*

_____ _____ _____

Print your name Date Signature

RESPONSIBILITY FOR PAYMENT

I agree to be responsible for the fees owed to The Woman's Health Pavilion ["the practice"] for services rendered to me should my insurance company deny payment for any reason whatsoever. I further agree to be responsible for all co-pays, deductibles, co-insurance and other amounts not covered by my insurance. If I do not have insurance or if my insurance is not effective on the date of service, I agree to be responsible for the fees for the services provided.

I agree to notify the practice immediately of any changes in my insurance. I acknowledge that a failure to do so may result in a denial of coverage for a variety of reasons including but not limited to inability of the practice to obtain pre-certification or pre-authorization of benefits. In such event, I shall be responsible for fees for denied services.

I acknowledge that each insurance carrier offers a multitude of specific plans; as such, it is not possible for the practice to determine exactly what coverages my plan allows. I acknowledge that as a covered subscriber, it is my responsibility to determine allowed coverage, and to understand deductibles and co-pays which may apply for services rendered by the practice.

_____Initial

I further agree to provide the practice with a valid credit card for any payments due.

In the event I do not pay the fees including but not limited to co-pays, deductibles, co-insurance or out of pocket expenses, or if my insurance does not cover all of the fees for the services provided by the practice, I agree to be responsible for collection costs incurred by the practice, including legal fees at the minimum rate of 40% of the principal amount due, court fees, filing fees, and interest thereon from the date of service through the date of payment at the greater of 16% per annum or the maximum amount permissible by law. I understand that unpaid charges over 60 days past due may be forwarded to a collection agency and/or attorney for further collection efforts at the practice's discretion.

_____Initial

I authorize, release and consent to the use by **THE PRACTICE** of my protected health information as defined under HIPAA in order to collect fees that I owe **THE PRACTICE** for services rendered.

I hereby authorize Mayer J. Saad, M.D. P.C. to bill the credit card provided for outstanding balances on my account. This authorization will remain effective until revoked in writing by the card holder.

[ ] I acknowledge that the refusal to provide a valid credit card will make me responsible for payment within 30 days.

_____ _____ _____

CREDIT CARD NUMBER **EXPIRATION DATE** **SECURITY CODE**

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PRINT PATIENT NAME **PATIENT'S ACCOUNT NUMBER**

Acknowledgement of Receipt:
Notice of Privacy Practices

I have reviewed the Woman's Health Pavilion Notice of Privacy Practices, which details how my health information may be used and disclosed as permitted under federal and state law, and outlines my rights regarding my health information.

Patient Name: _____

Signed: _____

Date: _____

Relationship (if not patient): _____

For staff use only:

If patient/patient's representative refuses to sign acknowledgement, please document and date time notice was presented to patient and sign below.

Presented on (date and time) _____

By (name and title) _____

Pharmacy Information

New York State law requires prescriptions to be electronically submitted to your pharmacy. Please indicate where you would like your prescriptions sent.

Patient Name _____ DOB _____

Name of local pharmacy: _____

Pharmacy address: _____

_____

Pharmacy phone number: _____

Some insurers require "maintenance medications" (those medication which you will continue to take for months or more) to be processed through a "mail-away" pharmacy instead. Please indicate how we should process your maintenance medications:

Your mail-away ID # _____

Mail-away pharmacy name: _____

Mail-away pharmacy address: _____

_____

Mail-away pharmacy phone # _____

Mail-away pharmacy fax # _____

Please provide us with a copy of your pharmacy ID card*

_____ _____

Patient Signature Date Signed

Mayer J. Saad, MD PC, dba
The Woman's Health Pavilion, *and*
North Shore Woman's Health Pavilion

372 Post Avenue
Suite 106
Westbury, NY

82-12 151st Avenue
Howard Beach, NY

109-33 71st Road
Suite 2G
Forest Hills, NY

2950 Hempstead Turnpike
Levittown, NY 11756

Privacy Officer: Lucia Lapetri **EFFECTIVE DATE: 6-14-16**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.Please review it carefully.

We care about out patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (e.g. billing services), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. With the exception of your treatment, only the minimum information needed to accomplish other tasks will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may communicate with a pharmacist about your allergies, to ensure proper choice of medications for your treatment.

For Payment. We may use and disclose medical information about you to obtain payments for services rendered. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Healthcare Operations. We may use and disclose medical information about you for your healthcare operations to assure that you receive quality care. Example: We may use and disclose

medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made without Consent or Authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Our healthcare providers treatment activities
- For other covered entities' healthcare operations (to the extent permitted under HIPAA)
- For other covered entities' and providers' payment activities
- Use and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities
- We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Use and Disclosures of Protected health Information Requiring Your Written Authorization: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will only be made with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will thereafter no longer use of disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back ay disclosures we have already made with your authorization, and that we are required to retain your records of the care we have provided you.

You Individual Rights Regarding Your Medical Information Complaints. If you believe your privacy rights have been violated, you may file a complaint with the privacy Officer at this practice or the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period (up to ix years, and not before April 14,2003) for which you want to receive a list of disclosures. Your request should indicate in what form you want the list (e.g. on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you the cost for providing the list.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matter, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice. Unless you specifically indicate otherwise in writing, we reserve the right to share limited protected health information through any phone number, fax number, address, or e-mail account that you provide for the purpose of contacting you about your scheduled appointments, treatment, results, or payment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that maybe used to make decisions about your care. Usually this includes medical and billing records but does not included psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the privacy Officer of this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to medical information, you may request that denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may as us to amend the information. You have the right to request and amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. In addition, we may deny your request if the information with you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement or disagreement with us. We may prepare a rebuttal to you statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to Paper Copy of this Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a copy of the current notice, please request one in writing from the privacy Office at this practice.

Changes to this Notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of this notice with the effective date in the upper right hand corner of the first page.