ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Timothy C Johnson, MD, Yolanda Tun-Chiong, DO

Practice Address: Urban Medical Group, 128 Mott Street, Suite 202, NY, NY 10013

Phone: 646-355-3711 Fax: 212-300-4989 E-Mail: info@urbanmedicalgroup.com

E-MAIL RELEASE FORM

Date:

I,

want to communicate via e-mail with Urban Medical Group

on matters related to my health and /or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Name: _____

(Print Patient's Name or Name of Patient's Representative)

Signature: _____

(Signature of Patient or Patient's Representative)

Witnessed by: _____

(Print Name)

Signature: _____

(Signature of Witness)

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth (Age)	Social Security Number
Patient's Address		City	State / Zip
Home Phone		Mobile Phone	Email Address
Referred by		Primary Care Physician	Primary Care Physician Phone
Pharmacy	Pharmacy Phone	Pharmacy Address	

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone
Employer/School Address	City	State / Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State / Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient
Address	City	State / Zip

Signature of Patient or Authorized Guardian _____ Date _____

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

Have you ever had any of the following Gastroenterological symptoms? (Please check all that apply)

- ☐ Abdominal Pain
- ☐ Anal Pain
- ☐ Bleeding (Black, Red, or Maroon Stool)
- ☐ Change in Appetite
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Excessive Gassiness
- ☐ Gluten Intolerance
- ☐ Heartburn/Acid Reflux
- ☐ Jaundice (Yellow Skin, Dark Urine)
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Pain when swallowing
- ☐ Vomiting
- ☐ Weight Gain
- ☐ Weight Loss

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Blood Disorder (including clots)
- ☐ Blood Transfusion
- ☐ Cancer Type: _____
- ☐ Celiac Disease
- ☐ Colon Cancer Polyps
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Depression
- ☐ Duodenal Ulcer
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Frequent Urinary Tract Infections
- ☐ Groin Hernia
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Mouth Ulcer
- ☐ Obesity Surgery
- ☐ Osteoporosis
- ☐ Parasites
- ☐ Pneumonia
- ☐ Sexually Transmitted Infection
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Other: _____

Medications

What medications are you currently taking? (Include aspirin, blood thinners, vitamins, minerals, herbals, supplements, laxatives)

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

- ☐ ACE Inhibitors
- ☐ Adhesive Tape
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Fentanyl
- ☐ Iodine (including contrast dye)
- ☐ Latex
- ☐ Midazolam (Versed)
- ☐ NSAIDs (Ibuprofen, Naprosyn, Advil)
- ☐ Penicillin
- ☐ Seizure Medicines
- ☐ Sulfa
- ☐ Valium

Reactions: _____

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Colon Polyps
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Rheumatism
- ☐ Thyroid Disorder
- ☐ None of the Above
- ☐ Not Sure

Details: _____

Women Only

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Check if you have had any of the following:

- ☐ Endometriosis
- ☐ Ovarian Cyst(s)
- ☐ Menopause
- ☐ C/Section
- ☐ Tubal Ligation

Birth Control: ☐ Yes ☐ No If yes, type: _____

Hospitalizations & Surgeries

Reason	Date

Urban Medical Group PLLC
128 Mott Street Suite 202
New York, NY 10013

Assignment of Benefits and Statement of Services

I hereby assign and authorize payment made directly to Urban Medical Group of the covered insurance benefits, including Major Medical benefits, whether payable to me by Blue Cross Blue Shield, Medi-Gap and/or commercial insurance companies. I understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance and payments from insurance companies sent directly to me. In consideration of the medical services furnished to me, I hereby agree to pay Urban Medical Group any balance due within ninety (90) days from presentation of my bill. If my account should become delinquent and collection efforts become necessary, I agree to pay any collection fees incurred.

This assignment shall apply to all services now rendered and to be rendered in the future until it is revoked.

I have disclosed the names of all my health insurance providers including tie-in-coverage and I represent that such health care coverage is in full force and effect at this time.

If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization and certification.

I authorize the release of the medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

I am satisfied that I fully understand this assignment and its significance.

Signed:

_____
Patient's Signature

_____
Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Patient's SSN:

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) or Organization(s) authorized to receive the information:

Urban Medical Group

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used:

:

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1) I understand that this authorization will **expire** on *(insert date)*.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *(insert name of practice)* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*
You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM