REGISTRATION FORM

VICTOR HEALTH ASSOCIATES
6532 ANTHONY DRIVE, SUITE A
VICTOR, NY 14564

Josephine Barrett, M.D.
Kevin D. Penird, M.D.
Brian E. Piotrowski, M.D.
Philip S. Meaker, M.D.

Today's Date_____

ADULT PATIENT INFORMATION

First Name _____ MI ____ Last Name _____ Maiden _____

Birth Date ___/___/_____ SS# _____-____-_____ Gender ___M ___ F E-Mail _____

Address _____ City _____ State _____ Zip _____

Home Phone _(____)_____ Cell Phone _(____)_____ Work Phone _(____)_____

LAST Primary Care Physician _____ Reason for Transfer _____

Emergency Contact _____ Phone _____ Relation _____

Marital Status	☐Married	☐Divorced	☐ Widowed	☐Single		
Employment Status	☐ Full Time	☐Part-Time	☐ Retired	☐Unemployed	Employer _____	
Student Status	☐ Full Time	☐Part-Time	☐ N/A			
Ethnicity	☐ Hispanic	☐Non-Hispanic	☐ Decline			
Primary Language	☐ English	☐Spanish	☐ French	☐ Other _____		
Race	☐ White	☐ African American	☐ Asian	☐ Indian	☐Pacific Islander	☐ Decline

Insurance Information

Please fill out information completely for each policy. See reverse for more information on patient financial responsibility.

Primary Insurance _____
Patient ID# _____Suffix_____
Group #_____Effective_____
Deductible_____Copay_____

Subscriber Information (If different than Patient)
Name_____DOB_____
Subscriber ID#_____SS#_____
Gender__M __F Relation to Patient_____

Secondary Insurance (If applicable)_____
Patient ID# _____Suffix_____
Group #_____Effective_____
Deductible_____Copay_____

Subscriber Information (If different than Patient)
Name_____DOB_____
Subscriber ID#_____SS#_____
Gender__M __F Relation to Patient_____

Person Responsible for Payment Other Than Patient

Patients age 18 and over will be the person responsible for payment unless the patient has designated or been designated an individual to act on their behalf such as a power of attorney or guardian. Victor Health Associates reserves the right to attempt to collect balances owed using information obtained from this form.

Full Name _____ Relation to Patient _____
Address _____
Home Phone _____Cell Phone_____ Work Phone _____
Signature of Designated Individual _____Today's Date _____

Please continue registration form on back of page.

8/1/16

PATIENT AGREEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I, the undersigned, realize that I am financially responsible for all services rendered to me or my dependent.
I authorize Victor Health Associates, to apply for benefits on my behalf to my insurance carrier and for payment to be made directly to Victor Health Associates for services rendered to me. For those insurance plans that Victor Health Associates does not participate with, I realize that I am personally responsible for all co-payments, deductible and non-covered services.

I realize:

1. Copayments and coinsurance are due and payable at the time of the visit, as well as charge estimates for deductible plans. (This rule is part of your insurance company contract). A fee of $25 may be assessed if payment is not made at the time of service and a $25 fee will be charged for any returned checks.

2. Missed appointments, as well as cancellations and re-schedules within 24 hours of the appointment time, may result in a charge of $25. Additionally, multiple missed appointments could result in discharge from the practice. New patients will not be charged; however, we will not extend a second appointment to be scheduled.

3. Non-Covered Services are those that may not be covered under certain insurance plans or services provided to individuals without insurance or that are covered by an insurance the providers do not participate with (i.e. Medicaid). If I have no insurance coverage or if my insurance coverage is provided by a company other than one that Victor Health Associates accepts assignment from (including primary or secondary coverage), the cost of all services (or any remaining cost after submission to a policy we do participate with) will be the responsibility of the patient/parent/guardian/guarantor.

4. It is the patient responsibility to inform the office of any changes to contact information or insurance, as well as present a current insurance card at every visit. It is also the responsibility of the patient to provide their insurance with all necessary information needed for the office to bill on their behalf, this includes designating a provider as their PCP if required by their policy. *The full office Financial Policy is available by request.*

I directly assign all medical/surgical benefits to Victor Health Associates and authorize the office to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I have been given a copy of the office Notice of Privacy Practices.

I certify that the information I have provided on this form and any other office forms is correct and that I have read and understand the above, and will comply with office policy.

Signature of Patient / Individual Responsible for Account

Date

Printed Name of Patient / Individual Responsible for Account

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Victor Health Associates for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Beneficiary Signature

Date

Victor Health Associates

6532 Anthony Drive, Suite A, Victor, NY 14564

New Patient Health History Form

Instructions: Please complete all sections to the best of your ability.

Patient Name: _____ Nick Name: _____
DOB: _____ Home Phone: _____ Cell Phone: _____
Previous Primary Care Doctor: _____ Last Seen: _____

Marital Status: Single Engaged Married Divorced Widowed Significant Other

Name of Spouse/Significant Other: _____

Children's' Names and Ages: _____

Occupation/Employer: _____

Allergies: _____

Medical Problems: *List both current and past problems/concerns.*

Medical Problem	√ Current	Previous Surgeries	Date/Year
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	
7		7	
8		8	
9		9	
10		10	

Current Medications: *List all prescription and over the counter medications, attach additional pages if needed.*

Name	Dose	Times/Day	Reason	Prescriber
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Preferred Pharmacy Name and Location: _____

Specialists: *(Females please include gynecologist information).*

Name	Specialty	Last Seen
1		
2		
3		
4		

Victor Health Associates

6532 Anthony Drive, Suite A, Victor, NY 14564

Tobacco/Alcohol/Drug History:

Do you smoke cigarettes (now or in the past)? □Yes □No
How much: _____ packs per day How long: _____ years Quit when: _____

Do you smoke a pipe or cigar or use smokeless/oral tobacco? □Yes □No

If you smoke or use tobacco products, are you interested in quitting in the next month? □Yes □No

How many alcoholic drinks do you consume (beer,wine,liquor) _____/week

Has drinking alcohol ever caused health, legal, driving, family or work issues? □Yes □No

Have you ever used illegal or illicit drugs or have you used prescription medications to get high? □Yes □No
If yes, list drug(s):

Family History: *Identify Health problems which your family members, living or deceased, have had.*
(Identify with M=Mother, F=Father, S=Sister, B=Brother, GM=Grandmother, GF=Grandfather)

Cancers	Stroke/TIA _____	Thyroid Disease _____
Breast _____	Diabetes _____	High Blood Pressure _____
Colon _____	Heart Disease _____	Glaucoma _____
Prostate _____	Kidney Disease _____	Mental Illness _____
Other Cancers _____	High Cholesterol _____	Other _____

Health Maintenance: *Please enter the date (or best estimate) of completion and specialist name and location.*

Exam/Test	Date	Physician/Location
Dental Exam		
Eye Exam		
Pap/Pelvic Exam		
Complete Physical Exam		
Mammogram		
Colonoscopy		
Last Blood Work Completed		
Recent Hospitalizations		

Immunizations: *Please enter the date (or best estimate) of completion and the location.*

Name	Date	Physician/Location
Tetanus		
Shingles		
Pneumonia		
Influenza		
Other: _____		

Additional Health Information: *Please add any additional information that you would like your provider to know.*

_____
_____
_____

Signature of Patient _____ Date _____

Office Use Only
Reviewed- Physician Initial: _____ Date: _____ Reviewed-Nurse Initial: _____ Date: _____

INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM MY AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. PATIENT CONFIRMING THE AUTHORIZATION.

I give my authorization to use or disclose my protected health information as described in Section 2 below.

Individual Patient's Name: _____

Patient's Address: _____

_____

Date of Birth: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED.

Name of Person that you are authorizing to receive and use your protected health information and to be actively involved in my medical care, including but not limited to, picking up prescriptions and conversing with my provider or provider representative regarding my health and care.

Name: _____ Relationship: _____

Address: _____

_____

Telephone: _____

3. INDIVIDUAL PATIENT'S SIGNATURE.

I have had the chance to read and think about the content of this authorization and I agree with the statements made in this authorization. I understand that I may revoke this authorization at any time by giving written notice to VICTOR HEALTH ASSOCIATES.

Signature: _____ Date: _____

Victor Health Associates

Specialists in Pediatrics and Internal Medicine

6532 Anthony Drive, Suite A
Victor, New York 14564
Telephone: (585) 924-2100
Fax: (585) 398-1217

Authorization for Release of Medical Information

Please complete all required sections legibly in blue or black ink in order for us to process this request. Incomplete or inaccurate forms will not be accepted.

Patient Name:_____ Date of Birth:___/___/_____

Phone: (_____) _____ - _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize *Victor Health Associates* to obtain information from:

Name of Provider/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

PURPOSE FOR THIS REQUEST: *(Check one)* ____Transfer of Care ____Health Care ____Other (specify): _____

INFORMATION TO BE DISCLOSED *Please check #1or #2*

☐ **1) Complete Record** - **Please answer all by checking Yes or No to the right of each question**

- including alcohol/drug related information ___**Yes** ___**No**
- including information related to treatment for sexually transmitted diseases ___**Yes** ___**No**
- including mental health related information, such as depression, anxiety ___**Yes** ___**No**

☐ **2) Other**_____

AUTHORIZATION VALID FOR: (Check One)

☐ This request only.

☐ One year from the date of this authorization **OR** through _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that

- **My right to healthcare treatment is not conditioned on this authorization.**
- **I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form., except where a disclosure has already been made in reliance on my prior authorization.**
- **If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.**
- **Release of HIV–related information requires additional authorization.**

I further realize that under New York State Health Law, Section 17, charging for copies of medical records is permissible, and that the office will charge $0.75 per page for records.

_____ _____

Signature of Patient / Legal Representative Date

Print Name and Relationship to Patient (If requester is not the patient): _____

Effective Date: January 1st, 2016
Review Date: January 3rd, 2017

NOTICE OF PRIVACY PRACTICES

Victor Internal Medicine & Pediatrics, PC
Lauren Brugnoni, Privacy & Security Officer 585-924-2100

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 understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart on a computer known as an electronic health record/personal health. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. Text reminders are also available.

5. Check-In. We may use and disclose medical information about you by having you provide demographic information when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Copy of this Notice. You have a right to notice of our duties with respect to your health information, including right to a paper copy of this Notice. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of these rights, contact our Privacy Officer.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.