NEW PATIENT REGISTRATION PACKET

PLEASE REVIEW CAREFULLY.

RICHMOND
Pulmonary
MEDICINE

RICHMOND Pulmonary MEDICINE

Patient Rights and Responsibilities.

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

RICHMOND Pulmonary MEDICINE

Office & Financial Policies

CANCELLATIONS, NO-SHOWS, AND LATENESS

If you are unable to make your appointment, please give the staff 24 hours cancellation notice. If you do not show up and/or do not call us 24 hours in advance, we reserve the right to charge a $30.00 fee for the scheduled time that we were unable to give to other patients. This fee must be paid prior to your next visit. If you arrive 20 minutes or more after your scheduled appointment time, your appointment may need to be rescheduled.

CONDUCT AND BEHAVIOR

At Richmond Pulmonary Medicine, we pride ourselves in customer service and care with a personal touch. We strive to treat all patients with dignity and respect and work hard to maintain a positive environment. As patron's of our practice, our staff expects the same mutual courtesy. If you have a concern please address it with our staff and we will do our best to work with you to solve any concerns or issues that may arise to the best of our ability.

DISMISSAL

If you are dismissed from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. Reasons for dismissal include failure to keep appointments, frequent no-shows, non-compliance (which means you won't follow physician instructions about an important health issue), being abusive to staff, or failure to pay your bill. We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date of this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to you new doctor after you let us know who it is and sign a release form.

PRESCRIPTION REFILLS

A doctor MUST SEE YOU prior to prescribing a new RX, refills on antibiotics or controlled medications, and changing your existing medications.

MEDICAL RECORDS REQUESTS AND SPECIAL FORMS

There is a $30 fee for forms that Richmond Pulmonary Medicine is required to fill out on the patient's behalf, such as FMLA or other employer forms. Please have these forms filled out as much as possible and inform the receptionist of any forms needing to be filled out prior to your visit. Please allow up to 7 business days for the forms to be finalized. Payment is due at the time that you pick-up these forms. If you would like these forms mailed to you, payment will be due prior to mailing.

PAYMENTS

Payment for your office visit including previous balances, co-pays, deductibles, and co-insurance is collected prior to being seen. Please confirm that Richmond Pulmonary Medicine is an in-network provider with your insurance prior to your visit, unless you have out-of-network benefits. If Richmond Pulmonary Medicine is not, you will be responsible for the entire balance of your account.

Please notify us of any insurance or personal information changes prior to your visit. If you fail to provide us with the correct insurance information you may be responsible for the balance of the claim.

We must obtain a copy of a valid photo ID and your insurance card to provide proof of insurance. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you. Your remittance is due within 10 business days of receipt of your bill.

PRIVACY & PATIENT RIGHTS

We have implemented strict policies and procedures in compliance with the Health Insurance Portability and Accountability Act (HIPAA) in order to keep your health information secure. For a copy of our Notice of Privacy Practices or the Patient Rights and Responsibilities, please ask the receptionist.

PATIENT PORTAL

Richmond Pulmonary Medicine offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communication tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security.However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your e-mail account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone. If there is information that you don't want transmitted via online communication, please inform your practice.

Patient Acknowledgment and Agreement:

I acknowledge that I have read and fully understand this consent form regarding the Patient Portal. I understand the risks associated with the online communications between my physician and me, and the consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

PLEASE SIGN ACKNOWLEDGEMENT & AGREEMENT ON '*PATIENT SIGNATURE' PAGE.*

NEW PATIENT REGISTRATION PACKET

RICHMOND Pulmonary MEDICINE

Thank you for choosing Richmond Pulmonary Medicine for your healthcare needs.
The following New Patient Registration Packet will help our physicians get to know you in order to better address any health issues you may have. If you have any questions please do not hesitate to ask one of our staff members.

PATIENT INFORMATION			
First Name	*Last Name*		*MI*
Date of Birth	*Social Security Number*	*Gender*	
Marital Status [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed			
Street Address			*Apt/Suite*
City		*State*	*Zip*
Home Phone		*Cell Phone*	
Race [ ] White [ ] Black or African American [ ] Asian [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian or Alaska Native			
Ethnicity [ ] Hispanic, Latino, or Spanish Origin [ ] Not Hispanic, Latino, or Spanish Origin			
Employment Status [ ] Employed [ ] Self-Employed [ ] Unemployed [ ] Disabled [ ] Retired [ ] Student			
Occupation	*Employer*		
EMERGENCY CONTACT			
Name			
Phone Number		*Relationship*	

PHARMACY INFORMATION		
Pharmacy Name		*Phone Number*
Address (or Cross Streets)		
SECONDARY PHARMACY INFORMATION		
Pharmacy Name		*Phone Number*
Address (or Cross Streets)		
PRIMARY INSURANCE INFORMATION		
Name of Insurance Company		*Phone Number*
ID/Subscriber Number		*Group Number*
Subscriber Name		*Relationship to Patient*
Subscriber SSN	*Subscriber Date of Birth*	*Subscriber Gender*
SECONDARY INSURANCE INFORMATION (if applicable)		
Name of Insurance Company		*Phone Number*
ID/Subscriber Number		*Group Number*
Subscriber Name		*Relationship to Patient*
Subscriber SSN	*Subscriber Date of Birth*	*Subscriber Gender*
PRIMARY CARE PHYSICIAN (PCP)		
PCP Name		*Office Phone Number*
Office Address		

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PAST MEDICAL HISTORY

Please check if you have ever had or currently have any of the following:

- [ ] Allergic Rhinitis
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Bladder Issues
- [ ] Blood Clots
  - [ ] Pulmonary Embolus
  - [ ] Deep Venous Thrombis (DVT)
- [ ] Cancer
  - [ ] Lung Cancer
  - [ ] Other (Type _____)
- [ ] COPD
- [ ] Chronic Bronchitis
- [ ] Depression
- [ ] Dementia
- [ ] Diabetes
- [ ] GERD
- [ ] Gout
- [ ] Heart Trouble
  - [ ] Coronary Artery Disease
  - [ ] Myocardial Infarction
  - [ ] Congestive Heart Failure
  - [ ] Arrhythmia
  - [ ] Atrial Fibrillation
- [ ] Hepatitis (Type _____)
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Neurological Disorder
- [ ] Kidney Trouble
  - [ ] Chronic Kidney Disease
  - [ ] ESRD (*On dialysis*? Yes/No)
- [ ] Reflux
- [ ] Seizures
- [ ] Sleep Apnea
- [ ] Stroke
- [ ] Substance Abuse
- [ ] Thyroid Disorder
  - [ ] Hyperthyroid
  - [ ] Hypothyroid
- [ ] Ulcer
- [ ] Other _____
  _____

Past Surgical History *(Please list previous surgeries and approximate dates)*

Past Hospitalizations *(Please list reason and date)*

PAST MEDICAL HISTORY *(cont.)*

Have you ever received any of the following vaccines?

Pneumonia: [ ] Yes [ ] No

If *yes*, which vaccine? [ ] Pneumovax (*Date*_____) [ ] Prevnar (*Date* _____)

Influenza: [ ] Yes [ ] No If *yes*, when? _____

Shingles: [ ] Yes [ ] No If *yes*, when? _____

Have you had a:

Colonoscopy: [ ] Yes [ ] No If *yes*, please list most recent date: _____

Mammogram: [ ] Yes [ ] No If *yes*, please list most recent date: _____

Echocardiogram: [ ] Yes [ ] No If *yes*, please list most recent date: _____

Please list any major medical conditions of your immediate family members:

Father	[ ] Alive [ ] Deceased
Mother	[ ] Alive [ ] Deceased
Sibling	[ ] Alive [ ] Deceased
Other	[ ] Alive [ ] Deceased

SOCIAL HISTORY

Do you use tobacco? [ ] Currently [ ] Formerly [ ] Never	If *yes*, 1. how many years? 2. how many packs per day?
Do you drink alcohol? [ ] Yes [ ] No	If *yes*, what is your average consumption per week?

CURRENT MEDICATIONS *(Please also include over the counter medications, herbal supplements, and vitamIns)*

Name	*Dosage/Strength*	*Frequency*

DRUG ALLERGIES *(Please list)*

PATIENT SIGNATURES

Acknowledgement of Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices. I understand that Richmond Pulmonary Medicine has the right to change it Notice of Privacy Practices from time to time and that I may contact Richmond Pulmonary Medicine at any time to obtain a current copy.

SIGNATURE: _____ **DATE:** _____

Authorization for Release of Prescription Information

I hereby authorize Richmond Pulmonary Medicine to release any prescription information to the pharmacy listed on PAGE 1 of this document.

SIGNATURE: _____ **DATE:** _____

Acceptance of Financial & Office Policies

By signing below, I acknowledge that I have read, understand, and agree to the Richmond Pulmonary Medicine Financial and Office Policies Form.

SIGNATURE: _____ **DATE:** _____

Acknowledgement of Receipt of Patient Rights and Responsibility

By signing below, I acknowledge that I have read and understand the Patient Rights and Responsibilities letter.

SIGNATURE: _____ **DATE:** _____

Acknowledgment and Acceptance of Patient Portal Authorization

I acknowledge that I have read and fully understand the consent form and the Policies and Procedures regarding the Patient Portal. I understand the risks associated with the online communications between my physician and me, and the consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information.

SIGNATURE: _____ **DATE:** _____

[ ] I am declining activation of my Patient Portal Account

By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Policy.

E-MAIL ADDRESS: _____

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Social Security Number	*Date of Birth*
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, unless I check the appropriate box(es) in section 9(c). Otherwise, in the event the health information described below, in section 9(a), includes any of these types of information, and I initial the line on the box in section 9(b), I specifically authorize release of such information to the person(s) or entity indicated in Section 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 re-disclosing 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 (888) 392-3644 or TDD/TTY (718) 741-8300

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below in Section 7. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will expire upon completion of this determination/review or one year from the date this form is signed, whichever comes first.

4. I understand that signing this authorization is voluntary. I understand that the State Disability Review Unit requires the completion of this form in order to gather health information necessary for a disability determination. I understand that without this authorization, my eligibility for Medicaid benefits may be affected.

5. Information disclosed under this authorization might be re-disclosed by the Department of Health (except as noted under item 2), and this re-disclosure 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 government agency specified in Section 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:

RICHMOND PULMONARY MEDICINE, 2905 Hylan Blvd, Staten Island, NY 10306, P: 718 351-1212, F: 718-351-4114

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 Info _____ HIV-Related Info

9(b). Authorization to Discuss Health Information

By initialing here _____, I authorize _____ to discuss my health information with my attorney, or a governmental agency, listed here: _____

10. Reason for release of information:	*11. Date or event on which this authorization will expire:*
[ ] At request of individual	*12. If not the patient, name of person signing form:*
[ ] Other:	*13. Authority to sign on patient's behalf:*

All items on this form have been completed and my questions about this form have been answered. I have been provided a copy of the form.

Signature of Patient or Representative Authorized by Law _____ *Date* _____