

**Scarsdale Medical Group
Patient Registration Form**
*(***Please return to front desk once completed***)*

First Name _____ M.I. _____ Last Name _____

Home Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Phone _____ Fax _____ E-Mail _____

DOB _____ Sex _____ Marital Status _____ SSN _____

What MD are you seeing today? _____ Primary MD? YES NO Referring MD _____

Insurance Information

Primary Insurance Carrier _____ Policy Number _____ Group Number _____

Address _____

Subscriber Name _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber Employer Name _____

Employer Address _____

Employer Phone _____ Employer Fax _____

Secondary Insurance Carrier _____ Policy Number _____ Group Number _____

Address _____

Subscriber Name _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber Employer Name _____

Employer Address _____

Employer Phone _____ Employer Fax _____

Employer Information (If Different From Subscriber)

Employer Name _____

Employer Address _____

Employer Phone _____ Employer Fax _____

Insurance Authorization: I hereby authorize Scarsdale Medical Group, LLP to furnish any information to my insurance carrier concerning condition and to receive payment on my behalf if Scarsdale Medical Group, LLP agrees to accept assignment.

Patient signature

Date

*****PLEASE RETURN FORMS TO FRONT DESK ONCE COMPLETED*****

SCARSDALE MEDICAL GROUP LLP NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

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.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations, the Scarsdale Medical Group LLP (“Group”) is legally required to protect the privacy of your health information. We call this information “protected health information,” or “PHI” for short. It includes information that can be used to identify you and that we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. Your PHI is contained in a medical record that is the physical property of the Group and we are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in our office. You can also request a copy of this notice from the contact person listed below at any time.

How the Group May Use or Disclose Your PHI:

For Treatment. The Group may use your PHI to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also will record actions taken by them in the course of your treatment and note how you respond to the actions. The Group may, with your general consent, disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services. Additional consent may be required with respect to PHI related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise required by other State or Federal law.

For Payment. The Group may use and, with your general consent, disclose your PHI to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. The Group may use PHI about you for operational purposes. For example, the Group may use PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you.

Appointments. The Group may use your PHI to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

Required by Law. The Group may use and disclose your PHI as required by law. For example, the Group may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health. Your PHI may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. PHI may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties. PHI also may be disclosed to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants.

Health and Safety. Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Worker's Compensation. Your PHI may be disclosed in order to comply with worker's compensation laws.

Health Oversight Activities. Your PHI may be disclosed to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

Research Purposes. Your PHI may be disclosed in order to conduct medical research.

Specific Government Purposes. PHI of military personnel and veterans may be disclosed in certain situations. Your PHI also may be disclosed for national security and intelligence activities.

Family, friends, or others. Your PHI, but not your confidential HIV-related information, may be disclosed to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have already taken action in reliance upon the authorization.

Authorization for HIV-Related Information. Confidential HIV-related information (for example, information regarding whether or not you have ever been the subject of an HIV test, have HIV infection, HIV-related illnesses or AIDS, or any other information which could indicate that you have ever been potentially exposed to HIV) will not be disclosed to any person without specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and certain limited circumstances, to public or government officials (as required by law), to persons specified in a special court order, to insurers as necessary for payment for your care or treatment, or to certain persons who have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth by New York State law). When specific written authorization is required to disclose HIV-related information, it will consist of a HIPAA Compliant Authorization for Release of Medical Information and a New York State Confidential HIV-Related Information form.

Authorization for Marketing Communications. The Group will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, the Group is permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosures are permitted only to the extent that we have applied safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

What Rights You Have Regarding Your Protected Health Information:

You have the following rights with respect to your PHI:

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that the Group limit how the Group uses and discloses your PHI. You may not limit the uses and disclosures that the Group is legally required to make. Group will consider your request but is not legally required to accept it. If the Group accepts your request, they will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, the Group may terminate an agreement to a restriction.

The Right to Choose How the Group Sends PHI to You. You have the right to ask that the Group sends information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). The Group must agree to your request so long as the Group can easily provide it in the manner you requested.

The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that the Group has, but you must make the request in writing by completing a medical records request form. If the Group does not have your PHI but knows who does, the Group will tell you how to get it. The Group will provide you with the opportunity to inspect your PHI within ten (10) days of your written request. Upon the written request by you or any other qualified person, the Group will furnish copies of any PHI requested within sixty (60) days from receipt of the written request. In certain situations, the Group may deny your request. In such case, the Group will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, the Group may charge you a reasonable fee for the costs of copying, mailing or other costs incurred in complying with your request. Instead of providing the PHI you requested, the Group may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

****Please note, that if you are the parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you. For example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services, may be restricted unless the minor patient provides an authorization for such disclosure. ****

The Right to Get a List of the Disclosures the Group Has Made. You have the right to get a list of instances in which the Group has disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

The Group will respond within 60 days of receiving your written request. The list the Group will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. The Group will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that the Group correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. The Group will respond within 60 days of receiving your request in writing. The Group may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. The Group's written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to have your request and the Group's denial attached to all future disclosures of your PHI. If the Group approves your request, the Group will make the change to your PHI, tell you that the Group has done it, and tell others that need to know about the change to your PHI.

The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

How to Complain About the Group's Privacy Practices

If you think that the Group may have violated your privacy rights, or you disagree with a decision the Group made about access to your PHI, you may file a complaint with the HIPAA Compliance and Privacy Officer, (914) 723-8100, x171. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W., Room 615F, Washington, DC 20201. The Group will take no retaliatory action against you if you file a complaint about the Group's privacy practices.

I _____ acknowledge receipt of the Scarsdale Medical Group LLP's Notice of Privacy Practices:

Signature: _____

Date: _____