

91 Gleneida Ave Ste A
Carmel, NY 10512
P: (845) 228-7000
F: (845) 228-5485

155 Route 6
Mahopac, NY 10541
P: (845) 621-7100
F: (845) 621-4942



ADVANCED HEALTH & INJURY CARE

GLENEIDA MEDICAL CARE

453 Route 21 East
Middletown, NY 10541
P: (845) 344-4040
F: (845) 344-4041

1579 Main St. POB 714
Pleasant Valley, NY 12569
P: (845) 635-8484
F: (845) 635-8491

Confidential Patient Information

How did you Hear about our office: Yellowbook Insurance Directory Doctor Referral?: _____

Internet: What website?: _____ Patient Referral?: _____

Pennysaver Health Newspaper Newspaper Ad Flyer Brochure Television Radio Walk in

Patient Name: _____ Social Security # : _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____ Marital Status: _____

Occupation: _____ Employer: _____

E-Mail: _____ Nearest Living Relative and Phone #: _____

Spouse's Name: _____ Spouse's Work Phone: _____

Reason For Visit: Please answer all Questions, Insurance companies Require for Authorization for Treatment.

Main Complaint: _____

Additional Complaints: _____

When Did It Start: _____

What Brought It On: Auto Accident Work Injury Yard Work Household Chores Sports Injury
 Lifting Something A Fall Exercising Shoveling Snow Slept Wrong No-specific Reason
 Other Please Specify: _____

What Makes it Worse: Work Sleeping Lying Down Sitting Driving House Hold Chores
 Yard Work Lifting Exercising Walking Taking Care of Children Increased Activity
 Other Please Specify: _____

What Makes It Better: Sitting Lying Down Sleeping Resting Exercise Shower Heat Ice
 Increased Activity Stretching Nothing Other Please Specify: _____

(Please Turn Over)

Current Medications: Tylenol/Acetaminophen Motrin/Advil/Ibuprofen Aleve/Naproxen Aspirin
 Muscle Relaxor?: _____ Prescription Pain Medication?: _____
 Prescription Anti-inflammatory?: _____ Neurontin Other?: _____

Other Doctors You are Seeing For This Problem: _____

Current Treatments: _____

Have You Had A Similar Condition In The Past: _____ How Long Ago: _____

How Was It Treated: _____

Any Allergies?: _____

Please List Any Major Health Problems : _____

Insurance Information:

Is This Due To An Auto or Work Related Injury? _____ Has A Claim Been Filed: _____

Health Insurance Company: _____ Policy #: _____

Primary Insured: _____ Insurance Company Phone #: _____

Authorization of Payment: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand and agree that this office will prepare any necessary paper work to assist me in making collection from the responsible insurance carrier and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt of payment. However, I also understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment for those services in full. I also understand that if I suspend or discontinue my care for any reason, any fees for services rendered are due and payable immediately. I also agree to assist this office in any way necessary, in collecting any payments due for services rendered to me by this office, from the responsible insurance carrier.

Consent to Treatment: I Consent to Medical Care, physical therapy, chiropractic, massage therapy, rehabilitations and related services at this facility. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. I also understand, acknowledge and affirm that on a rare occasion these services may lead to a temporary increase in pain or soreness, and on even more rare occasions more serious injuries can occur in patients compromised with certain concomitant disease or illness. This includes the 1 in 1million to 1 in forty million chance of cerebral-vascular accidents occurring during manipulation or mobilization of the neck, the same probability of this occurring while turning your neck or having your hair washed at a salon. This is generally attributed to an underlying defect in the vertebral or basilar artery.

Treatment of minors: I as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Wavier and release: I hereby release, discharge and acquit this facility, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, EMT, physician or urgent care service.

By signing below I acknowledge and agree to the above:

Patient Signature: _____ Date: _____

Guardian or Responsible Parties Signature: _____

Guardian OR Responsible Parties Social Security #: _____

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Glencida Medical Care, PC Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)

Date

Signature



HIPPA NOTICE OF PRIVACY

PLEASE INDICATE IF WE ARE ABLE TO LEAVE A MESSAGE ON YOUR MACHINE:

YES _____ OR NO _____

PLEASE LIST ANYONE THAT YOU WISH US TO DISCUSS YOUR MEDICAL CARE WITH:

NAME OF PERSON

RELATIONSHIP TO PATIENT



**ASSIGNMENT & INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR
PRIVATE & GROUP ACCIDENT AND HEALTH INSURANCE**

PATIENT NAME: _____
EMPLOYER: _____
DATE OF INJURY: _____
CLAIM#/GROUP#: _____
SS#:/ID: _____

I hereby instruct and direct the _____ Insurance Company
to pay by check made out to and mailed directly to:

COMPANY NAME: GLENEIDA MEDICAL CARE, P.C.
ADDRESS: 91 GLENEIDA AVE, STE A
CITY/STATE/ZIP: CARMEL, NY 10512

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct
and direct you to make out the check to me and mail it as follow:

C/O
COMPANY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____

For professional or medical expense benefits allowable, and otherwise payable to me
under my current insurance policy as payment towards the total charges for
professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY
RIGHTS AND BENEFITS UNDER THE POLICY.** This payment will not exceed
my indebtedness to the above mentioned assignee, and I have agreed to pay, in a
current manner, any balance of said professional fees for non-covered services and/
or fees over and above the insurance payment or as required by my insurance
policy.

A photocopy of this Assignment shall be considered as effective and valid as the
original.

I also authorize the release of any information pertinent to my case to any insurance
company, adjuster, or attorney involved in this claim.

Dated at _____ County, this _____ day of _____ 20 _____

Signature of Policyholder

Witness

Signature of Claimant, if other then Policyholder