Medical Associates
PRIMARY CARE | A MULTISPECIALTY GROUP
"THE CARE YOU CAN TRUST"

Welcome to Medical Associates

Dear New Patient,

We would like to take this opportunity to welcome you to **Medical Associates** and to thank you for choosing our physicians to participate in your healthcare.

Medical Associates is a PCMH (Patient Centered Medical Home) certified "Medical Home" utilizing a multidisciplinary approach to provide personalized, comprehensive health care focusing on wellness and prevention quality care for all patients. As continuity and coordination of patient care is essential in meeting your healthcare needs, board-certified physicians supported by trained staff work closely in a "team approach" to support your patient care by providing the best the best primary care.

Every effort is made to see our patients for medical problems during daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care. After hours care will be provided by the on-call physician, who can be reached by calling our office directly.

At Medical Associates, we use the latest healthcare technology to deliver effective medical care. We specialize in primary care, preventive care, annual physicals, and various specialties. We approach healthcare by focusing on all aspects of your health and overall well-being, including but not limited to, emotional, family, and social concerns.

Medical Associates accepts most of the insurances. **Before you visit, please notify your health insurance company of your new primary care provider if required. Please bring your health insurance identification card as well as a photo I.D.** We also request that you contact your previous physician and specialists and request that a copy of your medical record be sent to us. Please bring a complete list of all your medications, as well as the strength and dose of each one.

If you have any questions or need further clarification on our policies, please contact us through our website www.medicalassociatesnewyork.com or by speaking with an office manager.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to work with you.

Sincerely,

Medical Associates

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · ECHOCARDIOGRAPHY

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

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Please complete this form in its entirety and sign. Thank you.

Name: _____ DOB :_____
Last First M.I. MM/DD/YYYY

Social Security#: _____ Gender: ☐ Male ☐ Female

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Home #: (___)_____Cell#:(___)_____Work#: (___) _____

Preferred: ☐Home ☐Cell ☐Work

Email Address: _____

Employer: _____Occupation/Title: _____

Emergency Contact Name: _____ Emergency #:(____)_____

Relationship to the patient:_____

Preferred Pharmacy: _____ Phone#: (____)_____

Pharmacy Address: _____

I N S U R A N C E I N F O R M A T I O N

Primary Insurance Carrier: _____Effective Date: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date Of Birth: _____ Policyholder's Social Security#: _____

Insurance ID/Certificate#: _____ Group #: _____

PCP Selection Required: ☐Yes ☐No If yes please write the PCP name:_____

Secondary Insurance Carrier: _____ Effective Date: _____

Policyholder's Name: _____Relationship: _____

Policyholder's Date of Birth: _____ Policyholder's Social Security#: _____

Insurance ID/Certificate#: _____ Group #: _____

Responsible Party Information – ***Please complete if the responsible for payment is not the patient or the policy holder.***

Responsible Party's Name (Last/First) Responsible Party's SSN Relationship to Responsible Party

_____ _____ _____

Responsible party's Address: _____Phone#:_____

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I hereby authorize Medical Associates to release to my insurance company or its representative any information, including diagnosis and records, of any treatment or examination rendered to me during the period of medical care rendered by the above.

I authorize and request that my insurance company PAY DIRECTLY to Medical Associates, the amount due from my insurance company for such treatments rendered.

I also hereby confirm that all information noted above, and all insurance cards presented at this time is valid information. If my insurance carrier changes, I will present said valid information immediately. I will be responsible for all said balances in cases when I have not presented valid insurance information.

X_____ _____

Patient/ Parent/ Legal Guardian Authorized Signature Print Name Date

CONSENT FORM

I understand that Medical Associates may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment, and healthcare operations.

I understand that my consent is not needed if the law requires Medical Associates to report some aspect of my protected health information to a government agency, (for example, suspected abuse, communicable diseases and potential for serious bodily harm to myself or others).

I understand that I have the right to review Medical Associates privacy notice, to request restrictions on the use of my information, and revoke my consent later.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment or operations, Medical Associates may refuse to undertake my care.

_____

Patient/ Parent/ Legal Guardian Authorized Signature

_____ _____

Print Name Date

Contracted Insurance Carrier Fact:

Your insurance carrier has a time limit for submitting claims on your behalf. Our contractual agreement with your insurance requires that we receive accurate insurance information from you, to ensure that your claims(s) is submitted and processed in a timely manner.

Charges for claims denied due to expired/late claim submission, when we are in receipt of incorrect insurance, will be your responsibility.

Referral/PCP: If your insurance company requires you to choose a primary care physician (PCP) it is your responsibility to notify the insurance company that you have chosen your new physician. If you need an insurance referral to see a specialist, you must notify our office before the specialist's visit. If you have an outside PCP, you must obtain a referral for today's visit.

Please sign acknowledging your understanding of the above statement and the above information that you have provided is true to the best of your knowledge.

_____

Patient/ Parent/ Legal Guardian Authorized Signature

_____ _____

Print Name Date

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Notice of Privacy Practices

Our Obligations: Our office considers your privacy a priority. We follow strict federal and state guidelines to maintain the confidentiality of your protected health information. (PHI).

Protected Health Information: Protected Health Information (PHI) is any information about your past, present or future healthcare or payment for that care that could be used to identify you. Members of our workforce and our business associates may only access the minimum amount of protected health information they need to complete their assigned tasks.

We may use your PHI to treat you, obtains payment for services provided to you and conduct our normal business known as Health Care Operations. Examples of how we use and disclose information include:

Treatment – We document each visit. This includes test results, diagnosis, medications, and therapies. This allows our staff to provide the best care to meet your needs.

Payment – We use PHI to obtain payment for services we provide for you. We may tell your health plan about upcoming treatment or services that require prior approval.

Health Care Operations – We may use PHI in our internal operations to improve the quality or care and customer service we deliver to you.

Disclosure to Family, Friends and Caregivers – We may disclose PHI to a person identified by you, with your verbal or written consent. If you are incapacitated or in an emergency, we may exercise our professional judgment to determine whether disclosure is in your best interest.

Public Health Activities - We may disclose PHI for the following reasons: for public health such as disease tracking; to report abuse or neglect; for coroners or medical examiners; for workmen's compensation; for correctional institutions, for national security; for organ donation; to avoid serious public health or safety threat.

Highly confidential Information - the law requires special protections for the following information: HIV/AIDS status, genetic testing; psychiatric information; substance abuse/controlled substance use; venereal disease; abortion; A separate, specific authorization is required to release this information.

You may revoke your authorization at any time.

Our Responsibilities – We are required by law to maintain the privacy of your medical information, provide this notice of our duties and privacy practices, and abide by the terms of the notice currently in effect. We reserve the right to change privacy practices and to make new practices effective for all information we maintain. New policies will be posted in our office and available from our staff.

Your Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

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Law enforcement - Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Other uses and disclosures require your authorization - Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information:

Appointment reminders: Your health information may be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Fund raising: Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund raising efforts, please check off the following box:

☐ **Please do not use my information for fund raising purposes.**

If you have any questions about this notice, please contact our privacy officer who is the office manager.

If you would like to exercise your rights or feel your rights have been violated, contact the compliance officer at 631-361-2960. All complaints will be investigated, and you will not suffer retaliation for filing a complaint.

_____ _____

Patient Name (Please Print) Patient Signature

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Financial Policy

Medical Associates is committed to providing quality healthcare solutions for our patients. To contain the ever-rising cost of health care, we have implemented a Financial Policy, which explains the responsibility between Medical Associates and our patients.

Benefits differ within your insurance company (Aetna, Blue Cross/Blue Shield, Cigna, Medicare, United Healthcare, etc.). According to your insurance company, it is ultimately **your** responsibility to know what services will be covered. You can find this information *by calling the member services or customer services number* on your insurance card or by going to their website as a member/subscriber or patient.

PARTICIPATING INSURANCES:
Please present your most current insurance card at the time of your visit. It is your responsibility to provide us with the correct information so we may submit your claim correctly. *Inaccurate information* may result in a denied claim, making the insured responsible for the services charges.

By law, your insurance carrier must remit payment or deny your claim within 45 days of initial notice of a claim. If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier.

Contractually, we are required to collect all copayments *at the time of service*. We may also collect your deductible or payment for non-covered services, along with any patient balance, at the time of service. We verify your benefits, to the best of our ability, prior to each visit.

NON-PARTICIPATING INSURANCE
If we do not participate with your insurance, we will file your claim with your insurance and collect fees at the time of service. It will then be your responsibility to follow up with them regarding your claim.

SELF PAY PATIENTS
Patients without insurance coverage will be expected to pay *at the time of service*. If you will not be able to pay in full, you must ask to speak with our billing department, or an office manager so that payment arrangements can be made for you *prior to being seen.*

NO SHOW FEE
We understand that there may be times when you are unable to keep an appointment. If you need to cancel or reschedule, we kindly ask that you offer 24-hour notice during regular business hours.
Otherwise, you will be billed the following charges:

$25.00	Primary Care visit	$150.00	Stress Echo
$50.00	Specialist Visit	$150.00	Nuclear Stress Test
$50.00	Sonogram/per Study		

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RETURNED CHECKS

A $35.00 service charge will be applied to your account for returned checks. After the first returned check is received, only cash or credit card will be accepted.

BILLING & COLLECTIONS

We send monthly statements for any balances due. We ask you send your bill pay within 30 days from the date on your statement unless other arrangements have been made. If your balance is not paid within 60 days, your account could be referred to an outside collection agency. If this becomes necessary, you will be responsible for all collection fees, court costs, attorney fees, etc. You could also be discharged from our practice.

We understand that temporary financial problems may affect timely payments on your account. If such problems arise, we encourage you to call us; we can assist you in setting up a payment plan. Corporate: (631)361-2960

If you have any questions or concerns, please ask to speak an office manager. Thank you for choosing Medical Associates.

Sincerely,

_____ _____

Print Name
(person financially responsible)

Date

_____

Signature
(person financially responsible)

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Notice of Patient Responsibility - No Referral/PCP Selection

PCP (Primary care Physician):
If you are enrolled in an HMO and have not selected one of our providers as your PCP, you must contact your insurance company **prior** to being seen. You will be responsible for any charges denied by your insurance for not having a **referral or not selecting** one of our providers as your PCP. You will also be responsible for any charges applied to your coinsurance or deductible for not having a referral.

Referral
To see a specialist, most HMO insurances (Healthcare Management Organizations) require a referral from a PCP (primary care physician). The PCP is responsible for coordinating his/her patients' healthcare. The PCP *must* issue the referral **prior** to the patients' specialist visit. The referral must be for covered benefits under the insurance plan unless the visit regarding emergency care.

***If you visit a provider without changing him/her to your PCP or a specialist without a referral, depending on your plan type, you may be responsible for payment for all services rendered*.** You cannot change the PCP or receive a referral from your PCP **afte**r the service is rendered; retroactive referrals cannot be issued.
I have read the above and understand that I will be liable for any service rendered that is not covered due to not changing the PCP or having/obtaining a referral.

Thank you,
Management

Please acknowledge the policy by signing below:

_____ _____
Patient/ Parent/ Legal Guardian Authorized Signature **Date**

_____
Print Name

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No Show/Cancellation Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

To improve scheduling and reduce wait time, Medical Associates requires 24-hour notice for appointment cancellations and a 48-hour notice for Sonograms, Stress Echo and Nuclear Stress tests. The fee will be charged to your account as follows:

$25.00 - Primary Care Visit
$50.00 - Specialist Visit
$50.00 - Sonogram/Per Study
$150.00 - Stress Echo
$150.00 - Nuclear Stress Test

We thank you in advance for giving us the courtesy to cancel your appointment in a timely manner.

_____ _____

Patient/ Parent/ Legal Guardian Authorized Signature **Date**

_____

Print Name

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Annual Physical/Wellness Visit Policy

A wellness/yearly preventative exam, a "physical", is a periodic medical visit without problems or complaints, and is often a covered expense by your health insurance company on an annual, (once a year)**,** basis.

A preventative wellness exam **only** includes a medical history, a physical examination, risk factor reduction counseling, and the ordering of laboratory/diagnostic procedures appropriate for your age and gender. During the "Physical", testing such as an EKG, Sudoscan /ANS, Audiometry, Tympanometry, Spirometry and Bloodwork, can be deemed **not** part of your physical per your Insurance policy.

If an abnormality is encountered or a pre-existing problem is addressed during the same session as a scheduled preventative exam, you will also be charged for a problem-based office visit. Examples include, but are not limited to, reviewing prior laboratory or diagnostic test results with you, administering therapeutic injections and/or vaccinations, refilling or writing new medication prescriptions, arranging for referrals to specialists or other healthcare providers, and performing minor in-office surgeries or procedures. Please remember that all problem-based office visits are subject to the payment of deductibles, co-insurance and co-pays, and may result in an out-of-pocket expense to you – even if they are performed in conjunction with an otherwise free preventative exam.

It is a patient's responsibility to know their deductible or out of pocket expense. If you are unaware of your out of pocket expenses, please contact your insurance company at the member service number located on your insurance benefit card **prior** to your appointment.

Please acknowledge the policy by signing below:

_____ _____

Patient/ Parent/ Legal Guardian Authorized Signature Date

_____

Print Patient Name

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HIPAA Policy

I, (print name of patient), _____
Authorize Medical Associates to release/review the results of the following:
(initial below all that apply)

☐ Diagnostic/Preventive Test Results

☐ Blood work/Lab Results

☐ Radiology Results

☐ Billing Inquiries

☐ Other

To:

☐ Self

☐ My Spouse. Name: _____

☐ Leave Results Through Voicemail

☐ Leave Results with Family Member Who Answers the Phone

☐ Friend/Significant Other. Name: _____

☐ Fax Results to (specify name and number _____

I understand that this authorization will continue until I revoke it in writing and take full responsibility for any consequences that result from the above request.

_____ Date: _____
Patient Signature

_____
Print Patient Name

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Who should we thank for your referral?

- o Family
- o Friend
- o Zocdoc
- o Google
- o Yelp
- o Urgent care
- o Postcard
- o Insurance
- o Other _____

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Patient Name: _____ DOB: _____ Date: _____
Reason for Visit: _____
Additional issues you would like to address: _____

Past Medical History:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Alcoholism/other			Emphysema/COPD			Osteoporosis		
Allergies (environmental)			Enlarged Prostate			Other:		
Atrial fibrillation			Erectile dysfunction			Pneumonia		
Acid Reflux/GERD			Gallstones			Polycystic		
Allergies			Glaucoma			Positive PPD		
Anemia			Gout			Prostate		
Anxiety			Headaches			Psoriasis		
Arthritis			Hearing Loss			Seizures		
Asthma			Heart disease (specify type:			Stomach		
Back Disorder			Hemorrhoids			Stroke		
Bleeding Disorder			High Cholesterol			Thyroid		
Blood Clot			High Blood Pressure			TIA (Mini-		
Blood Transfusion			Irregular Menses			Tuberculosis		
Cancer (specify type:			Irritable bowel syndrome			Urinary		
Cataracts			Kidney Disease			Other		
Coagulation (bleeding or			Kidney Stones					
Colon Polyps			Liver Disease					
Chronic low back pain			Lupus					
Depression			Macular Degeneration					
Diabetes			Migraine Headaches					
Diverticulitis			Neck Disorder					

Medications: Please list all prescriptions and over the counter medications / supplements that you are taking

Name of Medication	Dosage	How Often	Date Started

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Patient Name: _____ DOB: _____ Date: _____

Allergies

Drug _____

Food _____

Environmental _____

Habits: *Do you ever use the following? If yes, how often?*

Tobacco	
Alcohol	
Recreational Drugs	
Caffeine	

How often do you exercise? *(Please circle the answer that is most relevant to you)*

☐ **Never** ☐ **1-2 times/week** ☐ **3-4 times/week** ☐ **5-6 times/week** ☐ **Daily**

Hospital Admission: ☐ Yes ☐ No _____ I have had no previous surgery.

Date	Reason	Hospital Name

Surgical History Admission: (Please list all prior operations and dates) _____ I have had no previous surgery.

Operation	Date	Reason

Family History *(Please also include any relatives with health problems)*

Family Member	Living	Deceased	Age	Disease
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Patient Name: _____

DOB : _____

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Date: _____

Health Screening (Please indicate if you have received that following screening test & date performed.

Screening Test	Yes/No	Date/Results	Screening Test	Yes/No	Date/Results
Cholesterol			Colonoscopy		
Blood Pressure			Mammogram		
Blood Sugar			Pap Smear		
EKG			Prostate Test		

Review of Systems (Please circle any symptoms you have experienced recently)

General	Ears	Eyes	Nose	Throat
Weight Gain	Hearing Loss	Vision Loss	Nosebleed	Hoarseness
Weight Loss	Ringing in Ears	Blurry Vision	Nasal Congestion	Sore Throat
Loss of Appetite	Wax Problem	Painful Eyes	Snoring	Itchy Throat
Night Sweats	Ear Pain	Redness	Postnasal Drip	Difficulty Swallowing
Fatigue		Drainage	Decreased Smell	Painful Swallowing
Swollen Glands				

Cardiovascular	Respiratory	Gastrointestinal	Urinary	Allergy
Chest Pain	Persistent Cough	Nausea / Vomiting	Painful Urination	Sinus Congestion
Irregular Heartbeat	Bloody Sputum	Abdominal Pain	Flash Pain	Hies
Palpitations	Difficulty Breathing	Heartburn	Nighttime Urination	Itchy Eyes
Swollen Legs	Wheezing	Diarrhea	Urine Leakage	Runny Nose
Painful Legs	Painful Breathing	Constipation	Difficulty Urinating	
		Bloody Stools	Frequent Urination	
		Mucous in Stools	Blood in Urine	
		Rectal Pain	Recurrent U	
		Rectal Bleeding		

Neuro	Skin	Musculoskeletal |	Hematologic	Psychiatric
Headache	Rash	Joint Pain	Easy Bruising	Difficulties with Sleep
Numbers / Tingling	Itchy Skin	Joint Swelling	Varicose Veins	Stress
Memory Difficulties	Dry Skin	Joint Redness	Excessive Bleeding	Feeling Depressed
Speech Problems	Change in Moles	Joint Stiffness		Feeling Anxious
Tremors	New Mole	Muscle Pain		Changes in Mood
Difficulty Walking	Hair Loss	Back Pain		Changes in Behavior
Lightheaded	Heat Intolerance			Suicidal Thoughts
Dizzy / Vertigo	Cold Intolerance			Eating Disorder
Fainting				Domestic Abuse

For Female Patients

Problems with Fertility? ☐Yes ☐ No
Abnormal Discharge? ☐Yes ☐ No
Are you satisfied with your sexual function & desire? ☐Yes ☐ No

Menstrual History:
Age of first Period_____ Age of Menopause _____
Frequency of Menses_____ Date of Last Menses _____
Pain during Menses? ☐Yes ☐ No
Heavy Bleedings ☐Yes ☐ No
Bleeding between Periods? ☐Yes ☐ No

Pregnancy History:
Number of Pregnancies_____Complications _____

For Male Patients

Problems with Fertility? ☐Yes ☐ No

Abnormal Discharge? ☐Yes ☐ No

Are you satisfied with your sexual function & desire?
☐Yes ☐ No