Catholic Health
Physician Partners

MEDICAL REGISTRATION FORM

(Patient Information Form – please fill out in its entirety)

PATIENT INFORMATION

Last Name:	**First Name:**	**Date:**
Date of birth:	**Sex Assigned at Birth: Female_____ Male_____ Not recorded on birth certificate_____ Unknown_____ choose not to disclose_____** **Sex Legal (gender identification) Male_____ Female_____ Other_____**	

PATIENT INFORMATION (DEMOGRAPHICS)

Current address:	**City:**	**State:**	**Zip Code:**
Home Phone: **Is it okay to leave a message?**	**Work Phone:** **Is it okay to leave a message?**	**Cell Phone:** **Is it okay to leave a message?**	

PLEASE CIRCLE PREFERRED TELEPHONE NUMBER ABOVE

Email Address:	

Do you have a Catholic Health EPIC MyChart Account?

GENERAL INFORMATION

Language: **Do you require an interpreter?**	**Marital Status: S M D W**

Ethnicity: (Please check) ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Do not wish to provide

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White

Religion:	**Do you work for Catholic Health?**	**Do you have any relatives that work for Catholic Health?**

EMPLOYMENT INFORMATION (PATIENT)

Employment Status: **F/T_____ P/T_____ Student_____** **Retired___ Unemployed_____**	**EMPLOYER:**		
Employer address:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

PATIENT RELATIONSHIPS/EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	**Phone:**	**Relation:**	
Address:	**City:**	**State:**	**Zip:**

PRIMARY CARE PROVIDER INFORMATION

Who is your Primary Care Provider:

VISIT INFO

Is today's visit accident or work related?

How did you hear about us? (TV, Newspaper, Physician, etc)

Pharmacy:	**Store No. (if known):**	**Phone:**	
Address:	**City:**	**State:**	**Zip Code:**

Referred By:
(REQUIRED FOR MEDICAL CLEARANCE APPOINTMENTS)

GUARANTOR INFORMATION (PATIENT 18 YRS AND OLDER)

Guarantor Name:

Date of birth:		**Phone:**	
Guarantor Address:	**City:**	**State:**	**Zip Code:**
City:	**State:**	**Zip Code:**	
Phone:	**Fax:**	**Email:**	

INSURANCE INFORMATION

Primary Insurance:	**Group No.:**	**Secondary Insurance: (Only if Applicable)**	**Group No.:**
Patient Relationship to Subscriber: (Please check) ☐ Self ☐ Spouse ☐ Father ☐ Mother Other		**Patient Relationship to Subscriber: (Please check)** ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other	
Subscriber ID:		**Subscriber ID:**	
Subscriber Name:	**Date of Birth:**	**Subscriber Name:**	**Date of Birth:**
Subscriber Address:		**Subscriber Address:**	**SSN:**

EMPLOYMENT INFORMATION (POLICY HOLDER)

Employer:	**Employment Status: F/T____ P/T_____ Student____ Retired___ Unemployed____**	**Date of Retirement:**	
Employer address:	**City:**	**State:**	
Phone:	**Fax:**	**Email:**	

Signature: _____ **Date:** _____

ALLERGIES

Medication Allergies:

Food Allergies:

Are you allergic to Latex, Shellfish or Iodine? Which one(s)?

MEDICATIONS

Medication / Supplements	Dose	Frequency

MEDICAL HISTORY

Check all that apply.

Heart Disease		Heart Murmurs		Heartburn/ GERD	
Liver Disease		Shortness of Breath		Anxiety	
Kidney Disease		Stroke		Depression	
Low Blood Sugar		Thyroid Problems		Menstrual Problems	
Diabetes		Cancer:		Sleeping Problems	
High Blood Pressure		Difficulty with Erections		Eating Disorders	
Asthma		Loss Of Sex Drive		Back Pain	
Emphysema		High Cholesterol		Neck Pain	
Irregular Heart Beat		Stomach Ulcers		Leg Pain	
Dizziness		Problems with Circulation		Arm Pain	
Fainting		Seizures		Abdominal Pains	

Other medical problems:

Surgical Procedures with Approximate Date:

Have you ever been tested for COVID19? _____ Date: _____ Pos_____ Neg_____

WOMEN ONLY

Are you pregnant / breast feeding?	How many pregnancies have you had?
Are you planning on getting pregnant?	How many live births have you had?
Last menstrual period?	Have you had irregular menses?
Difficulty becoming pregnant?	Do you have excess hair growth?

FAMILY HISTORY	
Mother's Medical History:	Living (Y/N):
Father's Medical History:	Living (Y/N):
Sibling(s) Medical History: Brother: Sister:	Living (Y/N):
Grandparent(s) Medical History: (please specify maternal or paternal)	Living (Y/N):

ALCOHOL USE

On average, how many total drinks per week of beer, wine or other alcoholic beverages do you have?

□less than 1 □ 1 - 5 □ 6 - 10 □11 – 15 □16 – 20 □greater than 20

SEXUAL ACTIVITY

Are you sexually active? Yes _____ No _____ Not currently active _____

Last Menstrual Period:_____

DRUG USE

Do you engage in recreational drug use? If yes, how often per week?

Which of the following drugs do you use?

Cocaine _____ Heroin _____ Marijuana _____ Oxycodone _____

Other? _____

Do you have a history of drug abuse?

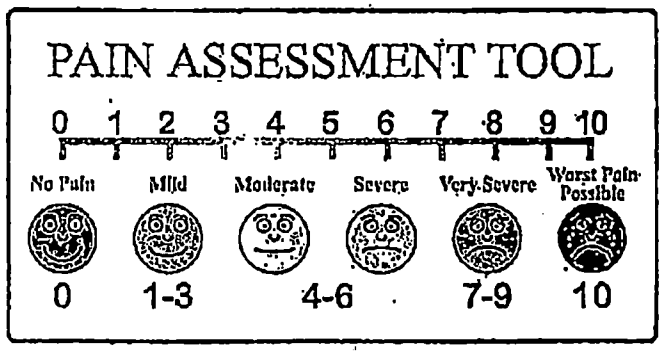
TOBACCO USE	
Are you currently a smoker?	What year did you start smoking?
Are you a former smoker?	How many packs per day? ¼ _____ ½ _____ 1 _____ 2 _____
How many years did you / are you smoking?	
Smokeless Tobacco	
Do you use smokeless tobacco? Yes _____ No _____ Never used_____	Are you a former or current smokeless tobacco user?
Do you snuff or chew tobacco?	If you quit using tobacco, when was your quit date?

SLEEP QUALITY	
What time do you: Wake up: _____ Go to Sleep	How many hours do you sleep? _____
Do you snore?	Have you been told that you snore?
Do you choke or gag during sleep?	Has someone seen you stop breathing while sleeping?
Do you wake up tired in the AM?	Do you wake up during the night?
Does your spouse snore?	How often?
Do you often feel like you need a nap?	For what reason?
Do you easily fall asleep while in a movie theatre?	Do you fall asleep while a passenger in a car?

Pain Screen

Are you currently in pain? _____ If so where? _____

Pain Number: _____



YOUR OTHER PHYSICIANS Please include doctors' name, location (town) and telephone number.	
Allergist	
Cardiologist	
Chiropractor	
Dermatologist	
Endocrinologist	
Ear, Nose and Throat	
Gastroenterologist	
Nephrologist	
Neurologist	
Neurosurgeon	
OB/GYN	
Oncologist / Hematologist	
Ophthalmologist	
Orthopedist	
Pain Management	
Past Family Doctor / PCP / Internist	
Psychiatrist	
Psychologist	
Pulmonologist	
Rheumatologist	
Urologist	
Vascular	
Other	

_____ __/__/____ _____ __/__/____

Doctor's Signature Date Patient's Signature Date

Catholic Health

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the end of this notice, and how I may obtain access to and control this information.

_____

Signature of Patient or Personal Representative

_____ _____

Print Name of Patient or Personal Representative Date/Time

_____

Description of Personal Representative's Authority

_____ _____

Signature of Facility Representative Date/Time

Catholic Health
Physician Partners

Patient Name_____ Patient DOB_____

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations Catholic Health may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit Catholic Health to disclose my protected health information for the purposes of appointment, test, procedure, reminders and follow-ups to the following individuals:

Name	Relationship to me	Phone #
Name	Relationship to me	Phone#

I expressly permit Catholic Health to disclose my protected health information for the purposes of appointment, test, procedure, reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel.#_____

Office voicemail: Tel. #_____

Other (specify)_____ Tel #_____

Signature of Patient	Printed Name	Date

Personal Representative

Parent/Guardian

Signature on File, Assignment of Benefits, Financial Agreement

Catholic Health
Physician Partners

BENEFICIARY NAME (print):		DATE OF BIRTH:	

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Catholic Health for services furnished me by Catholic Health. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Catholic Health accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. My signature authorization will remain on file unless I revoke authorization in writing.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Catholic Health, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Catholic Health may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Catholic Health for reimbursement for services rendered, and (2) any health care provider for continued patient care. Catholic Health may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **CLAIMS AUTHORIZATION:** I authorize payment of medical benefits directly to Catholic Health for services rendered.

5. **OTHER INSURANCE:** I understand that Catholic Health maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Catholic Health has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Catholic Health if I belong to a plan that does not appear on the above mentioned list.

6. **NON-COVERED SERVICES:** I understand that Catholic Health contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Catholic Health will provide me with an Advanced Beneficiary Notice for services that they suspect will not be covered, and I will be given the option to accept or decline said services. Accordingly, the undersigned accepts full financial responsibility for services that I have agreed to as reflected on the ABN, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Catholic Health to obtain necessary health care service plan authorizations.

7. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Catholic Health, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Catholic Health for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, is hereby assigned to Catholic Health. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Catholic Health. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

Beneficiary Signature or Authorized Party

Date

Catholic Health

Healthix

HIE - SCAN, HIE CONSENT, 3/23/22

CATHOLIC HEALTH HEALTH INFORMATION EXCHANGE (HIE), CARE EVERYWHERE, CAREQUALITY AND HEALTHIX CONSENT FORM

The Catholic Health ("CH") Data Warehouse (the "Data Warehouse"), Care Everywhere, Carequality and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website **www.ehealth4ny.org.**

In this Consent Form, you can choose whether to allow CH to share your medical records with your non-CH health care providers and to allow CH to access information about care provided to you by non-CH providers through the following health information technology platforms. These platforms can help collect the medical records you have in different places where you get health care and make them available electronically to the providers treating you. Your consent choice on this form will apply to all of the platforms.

CH Data Warehouse: You can Give or Deny consent to allow the participants (their employees, agents or members of their medical staff) with which CH has established connectivity ("HIE Participants") to access your electronic health information maintained in the CH Data Warehouse, including records from your other health care providers authorized to disclose information through the CH HIE.

Epic Care Everywhere, Sequoia Project, and Carequality: You can give consent to allow the health care providers, their employees, agents or members of their medical staff, listed on the Epic website **www.epic.com/careeverywhere** and Sequoia Project website **https://carequality.org/active-sites-search/** to access your health information maintained in the CH electronic medical record systems.

Healthix: You can Give or Deny consent to allow CH (our employees, agents or members of our medical staff) to see and obtain access to your electronic health records from your other health care providers authorized to disclose information through Healthix. **Healthix** is a Health Information Exchange or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the State of New York. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at **http://www.healthix.org** or by calling Healthix at (877) 695-4749.

Upon request, your provider will print the participating provider/information sources lists for you from the websites. The lists are updated regularly.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE. PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices: You can fill out this form now or in the future. You can also change your decision at any time by completing a new form. You have the following choices below. PLEASE CHECK BOX 1, 2 OR 3:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants with which CH has established connectivity to access ALL of my electronic health information available through the CH Data Warehouse, to ALL of the providers listed on the Epic and Sequoia Project websites to access ALL of** my **CH** electronic health records, and **to ALL employees, agents and members of the medical staff of CH to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants with which CH has established connectivity to access** my electronic health information through the **CH Data Warehouse, except for information they created,** and **I DENY CONSENT to ALL employees, agents and members of the medical staff of CH to access ANY of** my electronic health information through **HEALTHIX contributed by a non-CH participant** for any purpose, *even in a medical emergency.* I understand that I may be asked by Care Everywhere and Carequality providers at the point of care for authorization to access my CH electronic health information and they may access my information in an emergency as allowed by applicable law.

☐ **3. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY to ALL of the HIE Participants with which CH has established connectivity to access my health information through the CH Data Warehouse, to ALL of the providers listed on the Epic and Sequoia websites to access All of** my **CH** electronic health records, and **to ALL employees, agents and members of the medical staff of CH to access ALL of** my electronic health information through **HEALTHIX.**

Catholic Health

CATHOLIC HEALTH
HEALTH INFORMATION EXCHANGE (HIE),
CARE EVERYWHERE, CAREQUALITY AND
HEALTHIX CONSENT FORM

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your health information available through the CH Data Warehouse and Healthix. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by applicable law. **Checking the "I DENY CONSENT" box will not prohibit Epic Care Everywhere and Carequality providers from accessing your CH electronic health information in an emergency as allowed by applicable law.**

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at **www.healthix.org** or calling Healthix at **(877) 695-4749.**

My questions about this form have been answered and I have been provided a copy of this form.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date Time
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

CH HIE Care Everywhere and Healthix Fact Sheet

Details about patient information in the CH Data Warehouse, Care Everywhere and Healthix and the consent process:

1. Definitions.

- "Catholic Health" refers to:
  Advanced Rehabilitation Medicine, PLLC
  Cardiac EKG Interpretations, PC
  CHS Physician Partners ACO, LLC
  CHS Physician Partners IPA, LLC
  CHS Physician Partners, PC
  CHS Physician Partners PO, LLC
  Good Samaritan Hospital Medical Center
  Good Samaritan Nursing & Rehabilitation Care Center
  Good Shepherd Hospice
  Mercy Internal Medicine, PC
  Mercy Hospital
  Nursing Sisters Home Care, Inc. d/b/a Catholic Health Home Care
  Our Lady of Consolation Nursing & Rehabilitative Care Center
  Samaritan Emergency Medical Services, PC
  Samaritan Medical Services, PC
  Samaritan Pediatric Services, PC
  Southwest Suffolk Medical, PC