CONSTANCE STEWART, M.D. - 515 HEMPSTEAD AVE - ROCKVILLE CENTRE NY 11570 - 516.766.2199

NEW PATIENT INFORMATION SHEET

PATIENT NAME:				SEX:	
DATE OF BIRTH:		PATIENT SOCIAL SECURITY NUMBER:			
HOME ADDRESS:					
CITY:		STATE:		ZIP:	
TELEPHONE:		CELL:		WORK:	

ALLERGIES:

PHARMACY NAME:	
PHARMACY ADDRESS:	
PHARMACY TELEPHONE:	

EMERGENCY CONTACT INFORMATION:

NAME:		RELATIONSHIP:	
TELEPHONE:			

REFERRING PHYSICIAN:

NAME:		TELEPHONE	
ADDRESS:			

INSURANCE INFORMATION:

COMPANY:		ID NUMBER:	
NAME OF GUARANTOR:			
DATE OF BIRTH OF GUARANTOR:			
RELATIONSHIP TO PATIENT:			
INSURANCE PREFERRED LAB:			

PATIENT SIGNATURE:		DATE:	
PARENT/GUARDIAN SIGNATURE:		DATE:	

IF I AM A MANAGED CARE OR HMO PATIENT I ASSUME RESPONSIBILTY FOR ANY SERVICES THAT ARE NOT PART OF MY REFFERAL, AND WILL PAY FOR THESE SERVICES AT THE TIME THEY ARE PROVIDED.

I HEREBY REQUEST THAT MY INSURANCE COMPANY FORWARD ALL PAYMENTS TO MY DOCTOR, DR. CONSTANCE STEWART, FOR SERVICES RENDERED.

PATIENT SIGNATURE:		DATE:	

PLEASE SIGN THAT YOU HAVE READ OUR HIPPA LAWS. A COPY CAN IS IN THIS PACKET.

PATIENT SIGNATURE:		DATE:	

OFFICE POLICIES

PLEASE INITIAL BY EACH

NO SHOW AND FAILING TO CANCEL AN APPOINTMENT IS A $25 FEE.	
REFERRALS ARE A PATIENT'S RESPONSIBILITY, WITHOUT A REFERRAL YOU WILL NOT BE SEEN.	
COPAYMENT IS DUE AT THE TIME OF VISIT.	

HIPPA 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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

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 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. You then have the right to object or withdraw as provided in this notice.

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.

This notice was published and becomes effective on/or before April 14, 2003.

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. If you have any objections to this form, please ask to speak with HIPAA Compliance Officer in person or by phone at our main phone number.

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NAME: _____ DATE: _____

REASON FOR YOUR VISIT TODAY

HAVE YOU EVER BEEN TREATED FOR, OR DO YOU HAVE ANY OF THE FOLLOWING?

	YES	NO	DATE DIAGNOSED
NEUROLOGIC/BEHAVIOR PROBLEMS	☐	☐	
EYES, EARS, NOSE AND THROAT	☐	☐	
DUODENAL, PEPTIC ULCERS, COLITIS, OR INTESTINAL DISEASE	☐	☐	
TUBERCULOSIS OR LUNG CANCER	☐	☐	
HEART DISEASE OR PACEMAKER	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
KIDNEY DISEASE	☐	☐	
LIVER OR GALL DISEASE	☐	☐	
EMOTIONAL DISORDERS OR PSYCHIATRIC PROBLEMS	☐	☐	
URINARY OR BLADDER PROBLEMS OR INFECTIONS	☐	☐	
VENEREAL DISEASES	☐	☐	
DIABETES OR THYROID OR OTHER HORMONAL PROBLEMS	☐	☐	
TREATMENT WITH X-RAY	☐	☐	

SOCIAL HISTORY

DO YOU…	ALWAYS	SOMETIMES	NEVER
USE SUNSCREEN	☐	☐	☐
SMOKE	☐	☐	☐
DRINK	☐	☐	☐

PRIOR HOSPITALIZATIONS AND SURGERIES

PLEASE USE BACK OF SHEET IF YOU NEED ADDITIONAL SPACE

REASON	DATE

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD:

CONDITION	YES	NO	CONDITION	YES	NO
ALLERGIES	☐	☐	HAYFEVER	☐	☐
ASTHMA	☐	☐	HIVES	☐	☐
DIABETES	☐	☐	PSORIASIS	☐	☐
ECZEMA	☐	☐	SKIN CANCER	☐	☐

HAVE YOU EVER HAD?

CONDITION	YES	NO
DIFFICULTY WITH THE HEALING OF WOUNDS	☐	☐
EXCESSIVE BLEEDING WHEN CUT	☐	☐
OVERGROWN SCARS OR KELOIDS	☐	☐
ALLERGIC REACTIONS TO LOCAL MEDICATIONS	☐	☐

WOMEN ONLY

	YES	NO
ARE YOU PREGNANT?	☐	☐
ARE YOU PLANNING ON BECOMING PREGNANT?	☐	☐
WHEN WAS YOUR LAST PERIOD?		

ARE YOU ALLERGIC TO ANY MEDICATION OR OVER THE COUNTER REMEDIES (PLEASE LIST)?

ARE YOU UNDERGOING TREATMENT FOR ANY MEDICAL CONDITION NOW? IF YES, WHAT CONDITIONS?

DO YOU HAVE A HEART VALVE PROBLEM OR AN ARTIFICIAL JOINT THAT REQUIRES PREMEDICATION? IF YES, PLEASE EXPLAIN.

PATIENT SIGNATURE: _____ DATE: _____