SISSELMAN MEDICAL GROUP, PC
627 Broadway, Suite 1 Tel: (516) 308-4040 2171 Jericho Turnpike, Suite 304 Tel: (631) 670-6525
Massapequa, NY 11758 Fax: (516) 804-6386 Commack, NY 11725 Fax: (631) 670-6526

Patient Name: _____ **Date of Birth**: _____

Please fill out either section I OR section II and sign below:

Section I:

A. I, _____ give Sisselman Medical Group, PC, permission to leave information on my answering machine or with the following family member(s) or designated representative(s) as noted below:

B.

□ Answering Machine: _____

□ Family Member(s) or designated representative(s) (Please print full name and relationship.

_____

_____

Please check **all** information that can be left on the above answering machine(s) and/or with the above representative(s):

□ Test Results
□ Lab Results
□ Confirming Appointments
□ Medication Changes
□ Billing/Insurance Changes
□ Any information pertaining to all aspects of my medical care, including all of the above.

PLEASE NOTE THAT IF YOU DO NOT CHECK OFF SECTION B, WE WILL NOT LEAVE MESSAGES.

Section II:

□ I, _____, do not want any information pertaining to all aspects of my medical care left on my answering machine or with anyone other than myself.

CONSENT TO TREAT A MINOR CHILD
The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors and staff of Sisselman Medical Group, PC to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied to guarantee of cure.

Signature: _____ **Date**: _____

Relationship to patient _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices, which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my rights and the practices legal duties with respect to my protected health information. I have been provided to review the Notice of Privacy Practices and understand that I can obtain a copy on request.

Signature: _____ **Date**: _____

Relationship to patient (if minor, or signed by personal representative): _____

SISSELMAN MEDICAL GROUP, PC
Stephen G. Sisselman, FACP
Jill C. Sisselman, FAACP

Date: _____

PARTICIPATING INSURANCE

I, _____ have been informed on this date _____ by Sisselman Medical Group that if my health plan does not cover routine physicals, testing done in conjunction with my physical exam, any type of surgery or any vaccines that I have been given, I (the patient) will be personally responsible for the charges incurred and in the event of non-payment, I would be responsible for any fees incurred in an attempt to collect the balance. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. I understand that Sisselman Medical Group will bill my insurance company on my behalf.

_____

Patient or Responsible Party Signature

SERVICE FEE FOR NON-CANCELLATION OF APPOINTMENT

I, _____ am aware that if I have an appointment scheduled at Sisselman Medical Group and I am unable to keep this appointment, I will be charged a service fee of $20.00 if I do not call to cancel my appointment within 24 hours.

I understand that by not calling to cancel my appointment, I am holding an appointment in the doctor's schedule that could be used for another patient.

_____

Patient or Responsible Party Signature

PRESCRIPTION DATABASE CONSENT FORM

I, _____ give Sisselman Medical Group permission to access RX HUB (prescription database) to view my prescription history. As of August 27, 2013, consulting the prescription database is a New York State law for both providers and pharmacists. Failure to sign this document could restrict your provider from prescribing certain controlled substances.

_____

Patient or Responsible Party Signature

_____

Witness

SISSELMAN MEDICAL GROUP - *New Patient Medical History*

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Past Medical History ***Today's Date:***

Condition / Disease	***Year began***	***Condition / Disease***	***Year Began***
❑ Hypertension		❑ Diabetes	
❑ High Cholesterol		❑ GERD or other digestive issues	
❑ Hypothyroidism (low thyroid)		❑ Depression or Anxiety	
❑ COPD, Emphysema or Asthma		❑ Heart Problems (specify)	
❑ Cancer (specify)		❑ Other	

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

Other Physicians and Specialists *List below your other physicians (i.e., Gyn, Dermatology, Orthopedic, etc.)*

Medication / Food Allergies *List below medications or foods causing an allergic reaction (i.e., rash, swelling)*

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

Medications, Vitamins and Herbal Supplements

Medication	***Strength***	***Dosage***	***Medication***	***Strength***	***Dosage***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

Social History

Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
Occupation:	Hours worked per week:	

Family Health History *List below the health history of your blood relatives*

Relative	***Current age or age at death***	***Health problems and age at diagnosis***
Father		
Mother		
Brother(s)		
Sister(s)		

Review of Systems *Please review the following symptoms, circle those items that you experience*

Fever / Chills / Sweating	Chest Pain	Gallstones	Headaches	Anemia
Fatigue / Weakness	Palpitations	Diarrhea	Numbness	Excessive hunger
Sore Throat	Shortness of Breath	Constipation	Tingling	Excessive thirst
Earache	Wheezing	Incontinence	Seizures / Tremor	Easy bruising
Nasal Drip/Sinus Problems	Cough	Frequent Urination	Fainting	Breast discharge
Hoarseness	Heartburn	Kidney Stones	Weight Loss / Gain	Lumps in breast
Nosebleeds	Nausea	Muscle Pain	Trouble Sleeping	Heat/cold intolerance
Hay Fever	Vomiting	Arthritis	Anxiety / Depression	Rash / Itch
Hearing Problems	Abdominal Pain	Joint Pain / Stiffness	Bipolar	
Vision Problems	Rectal bleeding			

SISSELMAN MEDICAL GROUP, PC
CREDIT CARD AUTHORIZATION FORM

The purpose of this form is to authorize Sisselman Medical Group to retain a valid credit card number on file for you as our patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information. We find it necessary to do this because of changes in health care law and changes to your health plan starting 1/1/2014.

Your supplied credit card will be charged ONLY under the following circumstances:

- To satisfy any balances more than 60 days old, including co-pays and deductibles, for claims processed by your insurance carrier. If you do not send in payment for the balance due after receiving two (2) statements from us, we will charge your credit card for the outstanding balance. We will notify you when the card will be charged.
- To pay any returned check fees (not to exceed $35) in the event your check is returned to us for any reason.
- To pay for any Fee for Service testing, including any procedures not covered by your insurance and offered to you by us. For a list of our Fee for Service costs, please see the front desk.

A receipt will be kept in your chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account. **Either sign Part 1 OR Part 2.**

PART 1: Acknowledged, Agreed & Accepted:
Having read this form and speaking to staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X_____ X_____
Patient Signature (or authorized party) Date Staff Signature Date

NAME AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

CARD# (VISA/MC): _____

EXPIRATION DATE: _____ VERIFICATION CODE (3 digits)_____

DO NOT SIGN PART 2 IF YOU SIGNED PART 1

PART 2: Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with us your deductible will be due at the time of your visit. We reserve the right to send only one statement to the address on file to notify you of your balance with our practice. It is then your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and having your account closed with our practice. It is your responsibility to keep your information/demographics up to date with our office.

X_____ X_____ Patient

Signature (or authorized party) Date Staff Signature Date

Primary PartnerCare®

You and Your Doctor, Partnering for a Healthier You.

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Primary PartnerCare ACO Independent Practice Association, Inc. to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for Primary PartnerCare Associates IPA, Inc. to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Primary PartnerCare Associates IPA, Inc. to access my electronic health information through Healthix for any purpose.

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.

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

Primary PartnerCare® You and Your Doctor, Partnering for a Healthier You. Healthix

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Primary Partner Care Associates IPA, Inc. at 516-233-2483; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

627 Broadway, Suite 1
Massapequa, NY 11758
Phone: 516-308-4040
Fax: 516-804-6386

2171 Jericho Turnpike, Suite 304
Commack, NY 11725
Phone: 631-670-6525
Fax: 631-670-6526

PATIENT REGISTRATION FORM

(Please print clearly) ***Today's date:***_____

Last Name _____ First Name _____ MI _____

Home Address_____
Street *City* *State* *Zip*

Mailing Address if different_____
Street *City* *State* *Zip*

Home Phone _____ Work Phone _____ Other/Cell Phone _____

Birthdate: _____ Age: _____ SSN: _____ Email address: _____

Gender:	**Gender Identity**: How do you see yourself?	**Are You:**	**Student Status:**
☐ Male ☐ Female ☐ Other/unknown	☐ Male ☐ Female ☐ Not sure	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to specify	☐ Full time student ☐ Part time student ☐ Not a student

Race:	**Primary Language:**	**Marital Status**	**Employment Status:**
☐ White ☐ Black / African-American ☐ Asian ☐ Am. Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Decline to specify	☐ English ☐ Spanish ☐ Other _____ **Do you need an Interpreter?** ☐ Yes ☐ No	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner ☐ Other:_____	☐ Full time ☐ Part time ☐ Not employed ☐ Active military ☐ Retired ☐ Self-employed ☐ Unknown

MEDICAL INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____Group # _____

Name of Subscriber _____ Date of birth _____

Employer _____Relationship to Patient: _____

Address of insured (if different from patient) _____
Street *City* *State* *Zip*

SECONDARY INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____Group # _____

Name of Subscriber _____ Date of birth _____

Employer _____Relationship to Patient: _____

Address of insured (if different from patient) _____
Street *City* *State* *Zip*

Employment Information: Employer Name: _____

Employer Address _____
Street *City* *State* *Zip*

Responsible person: (if different from patient or if patient is minor)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____

Address_____
Street *City* *State* *Zip*

Relationship to patient _____

Mother's Maiden name _____

Person to contact in case of emergency: Name____ _____

Telephone # _____ Relationship to patient _____

Reason for Visit _____

Allergies to Medication: _____

Pharmacy: _____
Name *Street* *City* *Phone number*

Mail Order Pharmacy: _____
Name *Phone number*

How did you hear about our office? _____

How can we reach you to remind you of your appointments?

□ Home phone □ Work phone □ Cell phone □ Text Message □ Email □ Other _____

Signature on File: By signing below, I

- Authorize use of this form on all on my insurance submissions.
- Authorize release of information to all of my insurance companies.
- Authorize my health care provider to act as my agent in helping obtain payment from my insurance company.
- Authorize payment directly to my healthcare provider(s): Sisselman Medical Group, P.C.,
- Permit a copy of this authorization to be used in place of the original.
- Understand that I am responsible for my bill, including any copays, deductible, or coinsurance.
- Understand that if my health care providers accept assignment, I am responsible for any amount not paid by my insurance company, which may include any non-covered services.

Signature of Patient or Guardian _____ **Date**: _____

Patient Name: (print) _____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for _____ (name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name

Date of Birth

Signature

Date

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Sisselman Medical Group
Preventive Physical Exam Policy

An annual preventive exam done at Sisselman Medical Group may include the following procedures, tests and services:

- Preventive Exam (CPT codes: 99393 - 99397 for established patients, 99383 – 99387 for new patients. For Medicare-age patients, CPT codes are G0438, G0439 or G0402.)
- Electrocardiogram (CPT code 93000)
- Spirometry or pulmonary function test (CPT 94010)
- Otoacoustic emissions or hearing test (CPT 92587)
- Provocative tests for glaucoma (CPT 92140), usually done for those over the age of 50.
- TB skin test (CPT 86580)

In addition, there are several immunizations that are recommended:

- Tetanus, diphtheria and pertussis vaccine (90715)
- Influenza vaccine (90658)
- Pneumococcal or Prevnar vaccine (90732 or 90670)

These services are done or recommended in the best interest of the patient – especially in consideration of a patient's chronic conditions, family history and medications taken. **Please understand that any of the above mentioned tests or services done with your physical exam may NOT be considered preventive by your insurance plan and therefore may apply to a copay, deductible or coinsurance and you will be billed for those fees**. If a service is simply considered not covered, we reserve the option to reduce the fee to our self-pay rate and bill the patient (usually $25 per non-covered test; vaccines will be billed at our cost.)

It is in the patient's best interest to know his/her insurance policy and coverage guidelines as to which of these services are covered benefits, either for preventive care or for standard medical care. We try our best to check insurance eligibility and benefit information, but not all information is made available to us. Some policy provisions are not made known to us until a claim has been submitted and processed.

Please note that at the time of your wellness visit, **if you present with sick or acute complaints that are considered outside the scope of the preventive exam, an Office Visit may be charged and a balance may be due from you.**

I have read and understand that I may be financially responsible for balances due for those services performed during a preventive exam by Sisselman Medical Group.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____
(If patient is minor, parent or guardian)

9/19/16