METRO URGICARE

REGISTRATION FORM

(Please Print)

Today's date	Primary Care Physician

PATIENT INFORMATION

❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Last Name:	First Name	Middle	*Marital Status (Check one)* ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow(er)

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? (Former Name):	Birth date: / /	Age:	Gender ❑ M ❑ F	Social Security no:

Email Address:	❑ *Check box to opt out of future communications (email, print)*

Street Address:	P.O. Box:	Apartment/Suite #

City:	State:	ZIP Code:	Home Phone no: ( )

Occupation:	Employer Name:	Employer phone no:

Choose referral source (please check on box):
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Internet ❑ Newspaper ❑ Physician Referral _____
❑ Insurance Plan ❑ Hospital ❑ Flyer ❑ Pharmacy ❑ Presentation ❑ Employer
❑ School ❑ Other _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone no: ( )

Insurance carrier name	Address	Insurance phone no: ( )

Policy Number	Group#

Patient's relation to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable):	Policy Number:	Group number:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone no: ( )	Work phone no: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Metro UrgiCare or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

METRO URGICARE

AUTHORIZATION AND RELEASE

Authorization for Treatment: I voluntarily consent to the administration and cost of the medical and surgical procedures for myself or my dependent. Assignment of Insurance Benefits: I authorize payment directly to Metro Urgicare for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless y insurance is accepted. I also understand that if my insurance is accepted, I must pall all applicable insurance copays, coinsurances and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize Metro Urgicare to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer and follow up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of Metro Urgicare. I understand that a copy of the agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE: _____ DATE:_____

METRO URGICARE

Notice of Privacy Practices Acknowledgment

Metro Urgicare

1550 University Ave

Bronx New York 10452

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) **Date**

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices.

Date: _____

Staff Name: _____

HIPAA Notice of Privacy Practices

Metro Urgicare

1550 University Ave

Bronx New York 10452

Telephone 646 350 1616

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.

Metro UrgiCare

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.

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.

COMPLAINS

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 tens 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 Practice.