Registration

Name ________________________, ________________________ ____________________
Last *First* *Maiden (if applicable)*

Address ____ ____________________
Street Address *APT #*

____
City *State* *ZIP*

Home Phone ______________________ *Cell #* ______________________

*Social Security*________________________ *Date of Birth* __________________

Marital Status: S M D W *Occupation*______________________________

Primary Insurance____________________________________ *Copay $*________
**Please provide a copy of your card to the front desk*

*Policy Number*_________________________________ *Group* ___________________

*Policy Holder*_______________________________ SELF / SPOUSE / PARENT / OTHER__________

Date of Birth _______________ *SS#*______________________

Secondary Insurance____________________________________ *Copay $*________
**Please provide a copy of your card to the front desk*

*Policy Number*_________________________________ *Group* ___________________

*Policy Holder*_______________________________ SELF / SPOUSE / PARENT / OTHER__________

Date of Birth _______________ *SS#*______________________

I hereby assign and transfer to Melville Medical Care, all my rights and interests in medical reimbursement benefits under my insurance policy. I understand that I am responsible for all charges regardless of my insurance coverage. I authorize the release of my medical information for purposes of insurance processing.

PATIENT SIGNATURE ____________________________________ *DATE* ________________

Registration Cont.

Emergency Contact ______________________________ ____________________
Name *Phone Number*

Previous Primary Care Dr ____

Medication Allergies ____

Pharmacy ___________________________________ ____________________
Name/Address *Phone Number*

Release of Information: I give MELVILLE MEDICAL CARE *permission to discuss any information including all my medical records, test results or medical advice with the following individuals*

__________________________ __________________ ______________
Name *Phone Number* *Relationship*

How did you hear about our office? ___________________________________

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.
Your insurance policy is a contract between you and your insurance company. As a courtesy, we will bill your insurance company for services rendered. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. We will attempt to verify benefits for specialized services we perform; however,
you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
Most Insurance plans will permit the direct assignment of your benefits to our office. We accept insurance assignment. YOU ARE RESPONSIBLE FOR
ANY FEES YOUR INSURANCE DOES NOT COVER;This includes co-payment, co-insurance and yearly deductibles. Our office will make every effort to collect appropriate payment from your insurance company. However, if your insurance company fails to make payment within 120 days, the balance of your bill will become your responsibility.
Patients are expected to make their co-payments immediately after they have been treated.
24 hours notice is required for all cancelled/rescheduled appointments. There is a cancellation fee ($25.00) for missed appointments where notice has not been given. This fee will be billed directly to the patient. There is a service fee of $25 for all returned checks.
There is a $10.00 charge for medical forms to be completed by the doctor.

Patient Signature ______________________________ *Date*________________

Melville Medical Care
Sonia K. Qadir, MD
One Somerset Street
Huntington Station, NY 11746
Phone: (631)271-3075 – Fax: (631)271-3018

Communication Consent

It is the policy of Melville Medical Care not to release confidential and/or unauthorized information by home or work telephone, answering machine, voice mail, cell phone and or pager without patient permission. Whenever returning telephone calls and the answering machine pick-ups, we do not leave a message that would include private/personal information unless specifically given permission to do so. No information will be left with any unauthorized person who may answer the telephone unless permission is given below.

I authorize Melville Medical Care, and/or it's staff, to leave medical information pertaining to my care by the following methods: (I will assume responsibility to notify Melville Medical Care whenever this information changes).

________________ Yes _______ No_______
Home Phone

________________ Yes________ No_______
Answering Machine

________________ Yes________ No_______
Cell Phone

Patient Signature :__________________________ Date:__________________________

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NOTICE OF PRIVACY PRACTICES: PATIENT ACKNOWLEDGMENT

I,____, have received a copy of Melville Medical Care Notice of Privacy written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information.

____
Signature of Patient

____
Date

HIPPA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is composed of two main rules. The HIPAA privacy rule provides for the privacy of an individual's personally identifiable health information. The HIPAA Security Rule establishes standards for the privacy of electronic health information. HIPAA protects consumers from having their health information unnecessarily disclosed. The Department of Health & Human Services' Office for Civil Rights enforces HIPAA rules.

What is Protected

- HIPAA protects information in your medical records, including conversations between your doctor and nurses about your treatment. HIPAA also protects your billing information and any medical information in your health insurance company's computer system. Medical information which identifies you cannot be unnecessarily shared.

Who Must Follow HIPAA Laws

- HIPAA requires compliance by health care providers (doctors, hospitals, clinics and nursing homes), health plans (insurance companies, HMOs, company health plans, Medicare and Medicaid), and health care clearing houses. These are referred to as "covered entities" under HIPAA regulations, meaning they are covered by the law.

Who Need Not Follow HIPAA

- HIPAA protects your medical records with your doctors and health care providers; it does not cover all organizations which may have some of your medical information. HIPAA does not protect your information held by life insurance companies, employers, schools, or workers compensation carriers. HIPAA also exempts state agencies, municipal offices and law enforcement agencies.

Patient Rights

- You have a right to see your health records, and the right to copies of your health records. There may be a charge for copies of your records. You are required to be given a notice of how your information will be protected, used or shared. You also have the right to file a complaint with your insurance company, doctor, or with the U.S. Government.

Who can See Your Information

- HIPAA allows your information to be shared as necessary for your care, for billing, and for other limited purposes. These include protection of the public's health and for police to make reports of gunshot wounds. Your doctors cannot share your health information with your employer. Your information cannot be shared for advertising or marketing purposes without your written consent. Your health care providers may share your information with your family or others directly involved in or responsible for your care. You can prevent this sharing by making a written request.