GASTROENTEROLOGY of Hudson Valley

PATIENT REGISTRATION FORM

Name: _____ Social Security #:_____

Address:_____

City, State, Zip:_____

Birthdate:_____ Age: _____ Sex: M____F____ Marital Status:_____

Contact Information

Home Phone:_____ Cell Phone: _____

Email:_____

Emergency Contact

Name: _____Relationship:_____Phone:_____

Pharmacy:_____**Address:**_____**Phone:**_____

Primary Care Physician: _____ **Phone:**_____

Referring Physician: _____ **Phone:**_____

Insurance information: Do you have medical insurance? Y N

Primary insurance company:_____

Name of insured:_____ Soc. Sec. No:_____

Your relationship to the insured:_____ Birthdate of insured:_____

Secondary insurance company:_____

Name of insured:_____ Soc. Sec. No:_____

Your relationship to the insured:_____ Birthdate of insured:_____

Patient Signature:_____Date:_____

Assignment of Benefits/Office Policy Regarding Insurance

Your Responsibilities: At the time of appointment, it is the responsibility of the patient or guardian to provide our office with whatever documents are necessary for the insurance coverage to be effective. (This is typically just the insurance cards and a referral). It is the responsibility of the patient or their guardian to understand how their insurance plan works. The patient or their guardian liability for full payment remains with the policy holder.

If you do not have insurance: For our patients without insurance, we will charge a flat fee for an initial appointment and for any follow up appointments. These charges are only for the visits. Additional procedures (e.g. biopsies) will have additional fees that will be discussed at the time of the visit and should be paid at that time. For your convenience we accept all major credit cards.

Referrals and PCP: You are advised that the terms of your insurance benefit contract require you to obtain services from your participating insurance PCP and a referral form from your PCP before receiving the services you seek in order to be eligible for full benefit coverage related to this office visit. Please be further advised that the provider indicated above has confirmed with your insurance, if you proceed today to receive the service you seek in the absence of the required referral or confirmation of insurance coverage. The services will not be "covered services" under the terms of your benefit contract and you will be responsible for payment of amounts up to the providers FULL CHARGE for all services provided to you or your department. Please note that the PCP and Referral on file cannot be backdated. It is your right to contact your insurance company to change your PCP and have the right to arrange for the required referral before receiving the services you seek in order to have full benefits under the terms of your insurance benefit contract.

Authorization to Release Information to The Above Insurance Companies

I hereby authorize all medical and/or surgical benefits to Dr. G. Philip Sayegh. This includes all major medical benefits, Medicare/Medigap, HMO, and Government sponsored programs, or any other third-party payor for services rendered to me. I understand that I am responsible for all applicable DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND NON-COVERED SERVICES as required by my insurance policy.
I hereby authorize Dr. G. Philip Sayegh to release all information necessary, including medical records to secure the payment of insurance benefits.

Patient/guardian signature:_____ Date:_____

Medicare Only Patients

By signing below, I provide authorization for Medicare to assign benefits to my physician, Dr. G. Philip Sayegh.

Patient/guardian signature:_____ Date:_____

Notice of Privacy Practices

Dr. G. Philip Sayegh

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 describes the privacy practices of, wholly owned and controlled entities that engage in covered transactions under HIPAA (Health Insurance Portability and Accountability):
Dr. G. Phillip Sayegh is required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice.

How We May Use & Disclose Health Information-Treatment, Payment & Health Care Operations.
Dr. G. Philip Sayegh understands that information about you and your health is very personal. Therefore, we strive to protect your privacy. We are required by law to maintain the privacy of our patients, protected health information ("PHI") and to provide you with notice of our legal duties and privacy practices with response to your PHI. We will only use and disclose your PHI as described in this Notice. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice and to make the new notice provisions effective for all PHI we maintain.

Unless you expressly indicate to the contrary, you agree to receive such information from us and from the persons and entities with whom we share your PHI by automated means, which may include the use of an automatic telephone dialing system, pre-recorded messages, artificial voice and/or electronic mail ("email"), SMS (text messages) regarding treatment options, health-related information, disease-management programs, wellness programs or either community-based initiatives or activities in which we participate.
Treatment: We may use and disclose your PHI in connection with your treatment and/or other services provided to you- for example, to diagnose and treat you. In addition, we may contact you to provide appointment reminders or information about treatment alternatives to other health-related benefits and services. We may also disclose your PHI to other providers within (e.g., physicians, nurses, pharmacists, and other healthcare facilities involved in hour treatment).
Payment: We may use and disclose your PHI to obtain payment for services that we provide to you–for example, to request payment from your health insurer and to verify that your health insurer will pay for your healthcare services.
Healthcare Operations: We may use and disclose your PHI for our healthcare operations. These include internal administration and planning, various activities that improve the quality and cost effectiveness of healthcare services, healthcare delivery review, regulatory compliance, staff performance evaluation and training of physicians and other healthcare providers, business planning and development, business management and general administrative activities.We use this information to continuously improve the quality of care for all patients we serve. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other healthcare workers. We may also use PHI to resolve patient problems and complaints. Additionally, we may share your PHI with other healthcare providers and payers for certain business operations if the information is related to the relationship the provider and payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your protected health information.
Business Associates: We May contract with certain outside persons or organizations to perform certain services on your behalf, such as auditing, accreditation, legal services, etc. At times, it may be necessary for us to provide your information to one or more of these outside persons or organizations. In such cases, we require these business associates, and any of their subcontractors , to appropriately safeguard the privacy of your information as required by law.
Other Healthcare Providers: We may also disclose PHI to other healthcare providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain healthcare operations, for example, for emergency ambulance companies to request payment for services in bringing you to the hospital. Your Rights Regarding Your Protected Health Information.
Right to Inspect & Copy Your Health Information
You may request to see and receive paper or electronic copies of your medical and billing records . To do so, please submit written request to the appropriate Dr. G. Philip Sayegh. You will be charged for copies

in accordance with established professional, applicable state and federal guidelines and laws. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may be inaccessible to you under the law (for example, records relating to abortion, contraception, and/or family planning services and mental health services) unless the patient him/herself authorizes Dr. G. Philip Sayegh to give you access to this PH. Additionally, under limited circumstances defined by law, we may deny you access to a portion of your records.

Right to Request Restrictions

You may request additional restrictions on Dr. G. Philip Sayegh use and disclose of your PHI: For treatment, payment and healthcare operations, to individuals (such as family members, or other relatives, close friends or any other person identified by you) involved with your care or with payment related to your care, to notify or assist in the notifications of such individuals regarding your location in the hospital and your general condition, and to your health plan (i.r., third party insurer or healthcare payor) when the PHI is the result of a healthcare item or service that has been fully paid out of pocket. We are not required to agree with your request, and we may say "no" if it would affect your healthcare or if we reasonably believe the information is accurate as is in your record. If we agree to restrictions, we will state the need for purposes of treatment. If you wish to make a request to restrict the use of your PHI, please complete our Request for Restrictions of Protected Health Information:

Right to Receive Confidential Communications: You may request, and we will accommodate, any reasonable written request from you to receive your PHI by alternative means of communication at alternative locations. For example, you may instruct us not to contact you by telephone at home, or you may give us a mailing address other than your home for test results.

Right to Revoke your Authorization: You may revoke your authorization, except to the extent that we have already used or disclosed your PHI. A revocation form is available upon request form The Privacy Office, as noted below. This form must be completed by you and returned to the Privacy Office.

Right to Change Terms of this Notice

We may change the terms of this Notice at any time. If we change this Notice, we will post the revised Notice in appropriate ways. You also may obtain any revised notice by contacting: Dr. G. Philip Sayegh, in the 970 North Broadway Suite 307 Yonkers, NY 10701. Tel: 914-200-5083 Fax: 914-627-0206

Right to Receive Notifications

You have the right to receive written notification from Dr. G. Philip Sayegh in the event of a breach of your unsecured PHI. i.e., if there is an unauthorized access, use, or disclosure of your PHI which meets certain criteria under the law.

For information or complaints:

If you have a question or wish to file a complaint related to the privacy of your healthcare information, please call, email, or write to the Privacy Office using the contact information provided below.
Dr. G. Philip Sayegh, in the 970 North Broadway Suite 307 Yonkers, NY 10701. Tel: 914-200-5083 Fax: 914-627-0206

Patient Name: _____ **DOB:** _____

I acknowledge that I have been provided with a copy of the HIPAA notice and have been given the opportunity to read and ask questions about the notice. If I am unreachable in anyway, or anyone calls on my behalf, I authorize the office to release information only to:

Name	Relationship	Phone

Patient Signature:_____ **Date:**_____

Effective Date & Duration of this Notice
Effective Date
This Notice is effective from September 27, 2022
Date of Revision: 02/07/2023
This Notice was revised September 27, 2022

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Dr. G. Philip Sayegh - Gastroenterology of Hudson Valley 970 North Broadway Suite 307 , Yonkers, NY 10701

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**