PATIENT REGISTRATION FORM

DATE _____ ACCT. # (OFFICE USE ONLY) _____

NAME _____
(FIRST) (M.I.) (LAST)

ADDRESS _____

CITY_____ STATE_____ ZIP_____

SEX ☐ M ☐ F D.O.B._____ AGE_____ MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

SOC. SEC #_____ EMAIL _____

PHONE (CHECK PREFERED):

☐ HOME _____ ☐ CELL _____ ☐ WORK _____

OCCUPATION_____ EMPLOYER_____

BUS. ADDRESS_____

EMERGENCY CONTACT _____ RELATIONSHIP_____

TEL: ☐ H ☐ C ☐O _____

WHO REFERRED YOU TO DR. MARANS_____

WHO IS YOUR PRIMARY CARE DOCTOR OR INTERNIST_____

INSURANCE: MEDICARE #: _____ MEDIGAP: _____

INSURANCE CARRIER _____ POLICY # _____ GROUP # _____ COPAY ____

POLICY HOLDER'S NAME IF NOT PATIENT _____

RELATIONSHIP TO YOU _____ DATE OF BIRTH _____

I hereby authorize Hillel Y. Marans, MD to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of an insurance claim. If I am covered by Medicare, I authorize the release to the Centers for Medicare and Medicaid Services and its agents medical information which is needed to determine Medicare benefits and the benefits payable for related services. I request that payment under Medicare be made directly to Hillel Y. Marans, MD on any services furnished to me by that provider.

I authorize payment direct to Hillel Y. Marans, MD for services rendered. This authorization will remain in effect until it is cancelled by me in writing.

I agree to provide Dr. Marans with any referral authorizations from my primary care physician as required by my managed care insurance provider. I will be financially responsible for services sought without proper authorization.

I understand and agree that practice reserves the right to charge me or give future "standby only" appointments if scheduled appointments are cancelled with less than 24 hours notice.

SIGNATURE _____ DATE _____

*****Fee Schedules and Fee Estimates are Available Upon Request*****

Hillel Y. Marans, M.D., F.A.C.S.
Urology
352 Seventh Avenue
Suite 1003
New York, NY 10001-5012
Telephone 212-206-9130
Fax 212-206-9132
Email drmarans@econotek.net

APPOINTMENT CANCELLATION POLICY

Please help us avoid last minute gaps in our schedule!

Please be aware that cancellations with little or no notice disrupt our ability to provide timely medical care to all our patients. In an effort to minimize disruptions caused by appointment cancellations, our office has established the following guidelines:

- If you do not show up for your appointment OR you cancel with less than 24 hours notice, your appointment will be marked as a "No Show."
- Once you have accumulated more than two "No Shows" you will no longer be able to obtain a scheduled appointment. Instead, you will be placed on "Standby" status.
- Once you are on "Standby" status you must call the office on the day you wish to come to find out if there are open slots in the schedule. If there are open slots, you will be given an appointment. If there are none, you will have to call on another day. If you fail to show up for the standby appointment, you will be charged a $150 cancellation fee.
- At any time, if you wish to be removed from "Standby" status so that you can receive a scheduled appointment, you will be charged a $150 cancellation fee.
- If you require urgent care, bring this to the attention of the staff member who is handling your appointment. At the doctor's discretion, you will be given a scheduled appointment.

We ask for your cooperation in giving us timely notice if you have a need to reschedule your appointment.

Signature: _____ Date: _____

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Dear Patient: (For Office Use: Account # _____)

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals. When your health benefit plan pays your claim, they will let you and our office know what your payment obligations are for co-payments, deductibles and coinsurance amounts. It is our policy to obtain your credit card number or eCheck/ACH information and authorization so that we may process a payment for these remaining balances which your insurance plan indicates are your responsibility. This data will be stored on encrypted servers.

In providing credit card or eCheck/ACH payment information below, you authorize us to process payment for services which your health insurance says are your responsibility (including, but not limited to, co-payments, co-insurance, deductibles, and/or uncovered services**). Please fill in one of the two options below:**

☐ **CREDIT CARD PAYMENT**. A 3.5 % surcharge will be added.

Patient Name _____(For Office Use: Account # _____)

Name on Credit Card _____

Card Type: ☐ Visa ☐ Master Card ☐ American Express

Card Number _____ CVV # _____

Expiration date _____ Billing Zip Code _____

Signature _____ Today's date _____

☐ **eCHECK/ACH Payment.** No surcharge.

Bank Routing Number: _____ Account Number: _____

Confirm Account Number: _____

Patient Name _____Signature _____ Today's date _____

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 **Hillel Marans, MD** 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 to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, 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 **Hillel Marans, MD** to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for **Hillel Marans, MD** 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)

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
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
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 **Hillel Marans, MD** at 212-206-9130; 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, in case of a minor until he/she turns 18 years of age, or until 50 years after your death 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**.**