Dear Patient,

Welcome to our practice and thank you for choosing the Highland Medical, P.C., providers for your health care needs.

In order to expedite the registration process, please complete the new patient forms and bring with you to your first appointment. This will ensure that you are seen quickly and help us finalize the registration process efficiently and thoroughly. Also, please remember to bring the following items with you to your appointment:

- Your insurance card(s)
- Photo ID such as driver's license or passport
- Co-payment or deductible that your insurance requires (cash, check, or credit cards are accepted)
- List of all current medications, including dosage and frequency, and allergies
- Referrals that might be required prior to services rendered

We look forward to meeting and providing you with the quality healthcare services you deserve.

Sincerely,

The Staff at Highland Medical, P.C.

PATIENT INFORMATION:

last name | first name | middle initial

marital status | gender

street address | city/state/zip

home phone | cell | work

email address

date of birth | race | ethnicity | preferred language

occupation | employer

INSURANCE INFORMATION:

primary insurance | policy/ID number

cardholder's name | relationship | cardholder's date of birth

street address | city/state/zip

secondary insurance | policy/ID number

cardholder's name | relationship | cardholder's date of birth

street address | city/state/zip

Is this a work-related injury or illness? (please circle) YES NO

REFERRING PHYSICIAN INFORMATION (if any):

referring physician

telephone | fax

referring physician street address | city/state/zip

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of medical benefits to Highland Medical, P.C., for services rendered. I understand that I am financially responsible for any charges not covered by my insurance carrier(s). This may include deductibles, co-payments, co-insurance, and denied (non-covered) services.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as an original.

signature date

name date of birth

signature of parent/guardian (if minor) date

RELEASE OF INFORMATION:

I authorize Highland Medical, P.C., to release any necessary medical information to process my insurance claims.

signature date

signature of parent/guardian (if minor) date

GUARANTEE OF PAYMENT:

In consideration of services rendered by Highland Medical, P.C., I, the undersigned, agree to pay Highland Medical, P.C., any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided that I am informed of same prior to rendering of said services.

signature date

signature of parent/guardian (if minor) date

PATIENT COMMUNICATIONS:

In accordance with state and federal regulations, Highland Medical, P.C., wants to assure you that your personal medical information will be held in confidence and with the utmost respect. Please assist us in maintaining that confidence by completing this form. Please provide below the phone number(s) which we should use to contact you.

home phone cell work

LEAVING A CONFIDENTIAL MESSAGE:

Please indicate at which number, if any, you authorize us to leave a confidential voice message if we are unable to speak to you:

Phone Number for Confidential Message: _____

Initial Here: _____

EMERGENCY CONTACT:

Is there any person that you want us to contact in the event of an emergency or if we are unable to reach you?

_____

name relationship phone number

_____

street address city/state/zip

☐ I give Highland Medical, P.C., permission to discuss my personal health information with the individual listed above if I cannot be reached.

_____

name relationship phone number

_____

street address city/state/zip

☐ I give Highland Medical, P.C., permission to discuss my personal health information with the individual listed above if I cannot be reached.

I understand that Highland Medical, P.C., will adhere to the regulations outlined by HIPAA and will follow the guidelines I have outlined above.

_____

signature date

_____

signature of parent/guardian (if minor) date

Over the past few years, the number of different health insurance programs has increased at a significant rate. Even within one insurance company, there may be several programs with varying benefits and requirements. There is no way we can possibly know, or keep up to date with each insurance company's policies, programs, and provisions.

Some programs require a specific facility be used for your radiology and laboratory tests.
Some programs require pre-authorizations and notification of hospital and ER visits.
It is your responsibility to know:

1. Whether this office is participating with your insurance company and if they will cover physicals, immunizations, surgeries, etc.
2. To advise this office of your insurance requirements in advance, each and every time we provide a service. We will do our very best to comply with any responsible requirements your insurance company may have.

Please understand that if we have not been advised in advance of your insurance requirements or conditions and we provide a service or use a laboratory that is outside your insurance, you will be responsible for the appropriate fees. In addition, there may be times where we may not be able to obtain a consultant or laboratory that participates with your insurance. It is up to you to work this out with your insurance company.

Unless you carefully follow your insurance company's regulations, they may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to use if you have any questions about your coverage.

I acknowledge receipt of this information.

patient signature date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I have received a copy of the Highland Medical, P.C., Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

I understand that Highland Medical, P.C., reserves the right to change terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me with a revised Notice of Privacy Practices upon request. Furthermore, I understand that without my signed consent, medical information will not be released to any unauthorized individuals.

patient name	date of birth
patient signature	date
signature of parent/guardian (if minor)	date

Highland Medical, P.C.
OBS-GYN OF ROCKLAND

MEDICAL HISTORY

Doctor: _____

☐ New Patient ☐ Established Patient

_____

patient name | date of birth | age

_____

home phone | cell | date

What is the reason for your visit today?

☐ Annual pap smear and well women exam

☐ Problem, please describe: _____

Are there any questions you would like to discuss? YES NO

_____

REVIEW OF SYSTEMS: Please check all that apply at this time only.

Constitutional Symptoms		Respiratory		Skin/Breast	
	Weight Gain		Coughing		Breast Pain
	Weight Loss		Shortness of Breath		Lumps in Breast
Eyes			Wheezing		Nipple Discharge
	Glasses/Contact Lenses	Gastrointestinal			Rashes
	Vision Changes		Constipation	Endocrine	
Ears, Nose, Mouth & Throat			Diarrhea		Hot Flashes
	Cold Sores		Nausea/Vomiting		Sugar Problems/Diabetes
	Headaches	Genitourinary			Thyroid Problems
Cardiovascular			Frequent Urination	Psychiatric	
	Chest Pain		Incontinence		Anxiety
	Palpitations		Pain with Urination		Depression
	Swelling/Edema				Mood Changes

OFFICE USE ONLY: To be completed by the physician.

Date Reviewed: ____/____/____ Any Changes? YES NO _____
MD signature

Date Reviewed: ____/____/____ Any Changes? YES NO _____
MD signature

Date Reviewed: ____/____/____ Any Changes? YES NO _____
MD signature

Date Reviewed: ____/____/____ Any Changes? YES NO _____
MD signature

PAST HISTORY:

Do you have any medical problems? YES NO

If yes, please list: _____

Have you had any type of surgery? YES NO

If yes, please list: _____

Do you have any allergies? YES NO

If yes, please list: _____

Have you had an abnormal pap smear? YES NO

Do you have a history of sexually transmitted diseases? YES NO

If yes, please list: _____

What is your method of birth control? _____

When was your last menstrual period? _____ /_____ /_____

Period occurs every _____ days and lasts _____ days.

Is your period heavy? YES NO

intermenstrual bleeding? YES NO

Number or pregnancies? _____

Number of children? _____

Any miscarriages or abortions? YES NO

FAMILY HISTORY: Check all that apply.

	Diabetes		Uterine Cancer		Colon Cancer
	Heart Disease		Cervical Cancer		Osteoporosis
	Ovarian Cancer		Breast Cancer		Blood Clotting Disorder

SOCIAL HISTORY: Check all that apply.

	Tobacco Use		Alcohol		Drug Use

What is your occupation? _____

_____

patient signature date

_____

MD signature date

name _____ date of birth _____

pharmacy _____ pharmacy phone number _____

Please include all prescriptions, as well as all over the counter (OTC) medications, and vitamins/supplements taken on a regular basis.

Medication Name	Dose	Frequency

I do not take any medications consistently. (check here) _____

Consent to check medication history? Yes____ No ____

Dear Patient,

According to HIPAA Federal Regulations, each patient must be assured that his/her medical records are held in the strictest confidence. In order for Highland Medical, P.C., to comply with regulations, we ask that you take a moment to complete the following questionnaire.

Your signature is required where requested.

With what individuals may we discuss medical history, test, or lab results?

_____

name relationship to patient

_____

name relationship to patient

_____

name relationship to patient

Where may we contact you?: (please circle)

Home Phone: YES NO Phone Number:_____

Cell Phone: YES NO Phone Number:_____

Work Phone: YES NO Phone Number: _____

Email: YES NO Email Address: _____

I understand the Highland Medical, P.C., will adhere to the regulations as outlined by HIPAA and will follow the guidelines I have outlined above.

I have received Highland Medical, P.C., notice of Privacy Practices written in plain language. This notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

I understand that Highland Medical, P.C., reserves the right to change the terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request. I also understand that without a signed consent form the patient, medical information will not be released to any unauthorized individuals.

patient name | date of birth

patient signature | date

signature of parent/guardian (if minor) | date

Highland Medical, P.C.
OBS-GYN OF ROCKLAND

RECORDS RELEASE AUTHORIZATION

TO: _____

_____

I hereby authorize and request that my medical records be released to: Highland Medical, P.C.
At the following practices:

- ☐ Advanced Cardiovascular Care
  206 Route 303
  Valley Cottage, NY 10989
- ☐ Dr. Arthur Appel Internal Medicine
  119 Franklin Avenue
  Pearl River, NY 10965
- ☐ Dr. Arthur Appel Nephrology
  119 Franklin Avenue
  Pearl River, NY 10965
- ☐ Breast Surgery
  Nyack Hospital
  160 North Midland Avenue
  Nyack, NY 10960
- ☐ Clarkstown Medical Associates
  200 East Eckerson Road, Suite 160
  New City, NY 10956
- ☐ Family Practice Associates
  of Rockland
  206 Route 303
  Valley Cottage, NY 10989
- ☐ Hematology Oncology Associates
  of Rockland
  160 North Midland Avenue
  Nyack, NY 10960
- ☐ Highland Medical Gynecologic Oncology
  2 Crosfield Avenue, Suite 202
  West Nyack, NY 10994
- ☐ Highland Surgical Associates
  1 Crosfield Avenue, Suite 105
  West Nyack, NY 10994
- ☐ Dr. Kenneth B. Svensson
  Family Practice
  46 North Broadway
  Nyack, NY 10960
- ☐ Dr. Marc S. Zimmerman Medical
  Oncology and Hematology
  974 Route 45, Suite 1200
  Pomona, NY 10970
- ☐ Orangetown Family Practice
  97 Route 303
  Tappan, NY 10983
- ☐ Palisades Pulmonary
  2 Medical Park Drive, Suite 3
  West Nyack, NY 10994
- ☐ Pearl River Internal Medicine
  275 North Middletown Road, Suite 1F
  Pearl River, NY 10965
- ☐ OBS-GYN of Rockland
  510 Route 304
  New City, NY 10956

  20-21 Liberty Square
  Stony Point, NY 10980
- ☐ Rockland Neurology Associates
  2 Crosfield Avenue, Suite 202
  West Nyack, NY 10994
- ☐ Dr. Ronald A. Stern Internal Medicine
  18 Thiells Mount Ivy Road, Suite 4
  Pomona, NY 10970

Please send the medical records in your possession for the time period _____ concerning my treatment and/or illness.

*This authorization may include disclosures of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV-related information ONLY if I initial below:

_____ Alcohol/Drug Treatment
_____ Mental Health information
_____ HIV-related information

_____
patient name

_____
address city/state/zip

_____
patient signature date

_____
witness date