

Patient Information Sheet

SETAUKET  
SETAUKET RT  
SMITHTOWN  
PATCHOGUE

NEW ADDRESS / NEW NAME / NEW INSURANCE / NEW PATIENT / HOSP. F/U

PLEASE PRINT CLEARLY:

DATE: \_\_\_\_\_

Name: \_\_\_\_\_

Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_

Address: \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City State Zip

Ethnicity: \_\_\_\_\_

Race: \_\_\_\_\_

Pref Language: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City State Zip

Telephone #: \_\_\_\_\_ Full Time \_\_\_ Part Time \_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Full Time \_\_\_ Part Time \_\_\_

Pref Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ I.D.#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ I.D.# \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Name Address City State Zip Telephone #

Family Physician: \_\_\_\_\_

Name Address City State Zip Telephone #

Person To Contact In Case of Emergency: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Advanced Directives: (Circle one) Living Will Durable Power of Attorney DNR

Assignment of Benefits:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other Health Plan to: North Shore Hematology/Oncology Associates, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.\* I hereby authorize said assignee to release all information necessary to secure payment.

\*In the event this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE NOTE ATTACHED NOTICE OF PRIVACY PRACTICE FORM AND PATIENT RECORD DISCLOSURE FORM AS REQUIRED UNDER NEW HIPAA GUIDELINES MUST BE COMPLETED AND SIGNED

**NORTH SHORE HEMATOLOGY ONCOLOGY ASSOCIATES PC.**

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ What was the date of your last physical exam \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN \_\_\_\_\_ NEXT OF KIN \_\_\_\_\_  
 What is your chief complaint (Reason for VISIT) \_\_\_\_\_

**THESE ARE MANDATORY FIELDS --- YOU WILL NOT BE EXAMINED UNTIL THIS FORM IS FILLED OUT ENTIRELY**

When was your LAST Colonascapy \_\_\_\_\_ Where? \_\_\_\_\_ Never \_\_\_\_\_  
 When was your LAST Mammography \_\_\_\_\_ Where? \_\_\_\_\_ Never \_\_\_\_\_  
 When was your LAST Bone Density Exam \_\_\_\_\_ Where? \_\_\_\_\_ Never \_\_\_\_\_  
 When was your LAST Flu Shot? \_\_\_\_\_ When was your last Pneumococcal Vaccine? \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
 Do you Smoke? \_\_\_\_\_ Packs per Day \_\_\_\_\_ When did you Quit Smoking? \_\_\_\_\_  
 Do you want assistance with Smoke Cessation YES \_\_\_\_\_ NO \_\_\_\_\_ Alcohol use? YES \_\_\_\_\_ NO \_\_\_\_\_  
 Have you ever been exposed to toxic substances ie: Asbestos or chemicals YES \_\_\_\_\_ NO \_\_\_\_\_

**FAMILY HISTORY WHICH IS PERTINENT TO YOUR VISIT.**

FAMILY MEMBER	AGE	HEALTH			CAUSE OF DEATH	DUE TO CANCER
		GOOD	POOR	DECEASED		
FATHER						
MOTHER						
SISTER						
BROTHER						
SISTER						
BROTHER						

**DO ANY OF YOUR IMMEDIATE FAMILY HAVE THE FOLLOWING?**

DISEASE	RELATION	DISEASE	RELATION
CANCER		GI (STOMACH PROBLEMS)	
HIGH BLOOD PRESSURE		ARTHRITIS	
LUNG DISEASE		DIABETES	
KIDNEY DISEASE		HEART DISEASE	
ENDOCRINE (THYROID)		INFECTIOUS DISEASES	
ANEMIA BLOOD DISORDER		GOUT	
BLEEDING PROBLEM		MENTAL ILLNESSES OR NEURO	
SEIZURES		URINARY PROBLEMS	
SKIN DISORDERS		VASCULAR	

PAST SURGERIES	WHERE	PAST SURGERIES	WHERE

**YOUR PAST MEDICAL HISTORY**

DISEASE	CHECK BELOW	DISEASE	CHECK BELOW
CANCER		GI (STOMACH PROBLEMS)	
HIGH BLOOD PRESSURE		ARTHRITIS	
LUNG DISEASE		DIABETES	
KIDNEY DISEASE		HEART DISEASE	
ENDOCRINE (THYROID)		INFECTIOUS DISEASES	
ANEMIA BLOOD DISORDER		GOUT	
BLEEDING PROBLEM		MENTAL ILLNESSES OR NEURO	
SEIZURES		URINARY PROBLEMS	
SKIN DISORDERS		VASCULAR	

DO YOU HAVE ANY MEDICATION ALLERGIES: \_\_\_\_\_  
DO YOU HAVE ANY FOOD ALLERGIES: \_\_\_\_\_  
DO YOU HAVE A LATEX ALLERGY: \_\_\_\_\_

OTHER PHYSICIANS THAT CARE FOR YOU	YOUR LAST VISIT THERE	REASON FOR VISIT

PLEASE LIST ANY INFECTIOUS DISEASES YOU HAVE OR ARE BEING TREATED FOR  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU BEEN OUT OF THE COUNTRY RECENTLY \_\_\_\_\_ TO WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_

IS THERE ANY OTHER PERTINENT INFORMATION WE SHOULD KNOW THAT WOULD IMPACT YOUR CARE AND TREATMENT.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YOUR SIGNATURE IS REQUIRED \_\_\_\_\_ DATE \_\_\_\_\_

THANK YOU FOR YOUR HELP WITH THIS DATA COLLECTION. THIS INFORMATION IS INVALUABLE TO US AND HELPS US TO GET TO KNOW YOU BETTER. ALL OF THE INFORMATION IS CONFIDENTIAL AND WILL BE TREATED THAT WAY AT ALL TIMES. IF YOU HAVE ANY QUESTIONS REGARDING THIS INFORMATION OR NEED ANY HELP IN CLARIFYING THIS FORM FEEL FREE TO CALL.

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NORTHSHORE HEMATOLOGY/ONCOLOGY, ASSOC P.C  
235 NORTH BELLE MEADE ROAD  
EAST SETAUKET NY 11733  
OFFICE (631)751-3000 FAX (631)751-0506

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Date: \_\_\_\_\_ Medical record number \_\_\_\_\_

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home number: \_\_\_\_\_ DOB: \_\_\_\_\_

Authorization is hereby granted to \_\_\_\_\_

To provide: NORTHSHORE HEMA/ONC, ASSOCIATES, P.C

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

With access to my MEDICAL AND OR HOSPITAL RECORDS for the purpose of  
Review and request you provide such copies thereof that may be requested.

1. Records regarding admission and/or treatment for the following dates of service  
From: \_\_\_\_\_ To: \_\_\_\_\_

2. The following specified information:

- A. Blood work      Yes \_\_\_\_\_ No \_\_\_\_\_
- B. X-rays            Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Pathology        Yes \_\_\_\_\_ No \_\_\_\_\_
- D. All the above    Yes \_\_\_\_\_ No \_\_\_\_\_
- E. Specific: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



**NORTH SHORE  
HEMATOLOGY/ONCOLOGY  
ASSOCIATES, P.C.**

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- Home Telephone \_\_\_\_\_  
 O.K. to leave message with detailed information  
 Leave message with call-back number only \_\_\_\_\_
- Work Telephone \_\_\_\_\_  
 O.K. to leave message with detailed information  
 Leave message with call-back number only \_\_\_\_\_
- Written Communication  
 O.K. to mail to my home address  
 O.K. to mail to my work/office address  
 O.K. to fax to this number

Other (LIST HERE ANY FAMILY MEMBER WE MAY RELEASE MEDICAL INFORMATION TO.)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
 NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
 NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_

\_\_\_\_\_  
*Patient Signature* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name* \_\_\_\_\_  
*Birth Date*

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

*Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

**\*\*\* DO NOT WRITE BELOW THIS LINE \*\*\***

**(FOR OFFICE USE ONLY) (FOR OFFICE USE ONLY)**

**Record of Disclosures of Protected Health Information**

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized  
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations  
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we will try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

PLEASE CHECK ALL THAT ARE TRUE:

I have received the Notice of Privacy Practices (effective date April 14, 2003).

\_\_\_\_\_  
Patient's (or Legal Representative's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Legal Representative

*For office use only*

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?

Yes     No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try and obtain the patient's signature:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name/Title

\_\_\_\_\_  
Date

*Place completed Acknowledgement in patient's medical record.*

**North Shore Hematology / Oncology Associates, P.C.'s**

**NOTICE OF PRIVACY PRACTICES**

*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.*

**I. Our Duty to Safeguard Your Protected Health Information.**

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement.

**II. How We May Use and Disclose Your Protected Health Information.**

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

**For treatment:** We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a shoulder problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

**To obtain payment:** We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

**For health care operations:** We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send notice or call you as a reminder to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- ◆ We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- ◆ We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- ◆ We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health department. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- ◆ We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- ◆ In certain circumstances, we may disclose medical information to assist medical research.
- ◆ In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- ◆ If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people. We may also share medical information with these people to notify them about your location, general condition, or death.
- ◆ We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- ◆ We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You should understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

### **III. Your Rights Regarding Your Medical Information.**

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Medical Records Department at 631-751-3000. Specifically, you have the following rights:

- ◆ You have the right to ask that we limit how we use or disclose your medical information. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so.
- ◆ With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose

what portions of your information you want copied and to have prior information on the cost of copying.

- ◆ If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will change the medical information and so inform you.
- ◆ In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- ◆ You have a right to receive a paper copy of this Notice upon request.

#### **IV. How to Complain about our Privacy Practices:**

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, you may file a complaint with the person listed in Section V. below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at

Region II, Office for Civil Rights  
U.S. Department of Health and Human Services  
Jacob Javits Federal Building, Suite 3312  
26 Federal Plaza  
New York, NY 10278.

We will take no retaliatory action against you if you make a complaint but hope that you would first discuss your concerns with us and provide us with an opportunity to address them for you.

#### **V. Contact Person for Information, or to Submit a Complaint:**

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, in writing at:

North Shore Hematology/Oncology Associates, P.C.  
Attn: Privacy Officer  
235 N. Belle Mead Road  
East Setauket, NY 11733.

#### **VI. Effective Date:** This Notice was effective on **April 14, 2003.**

**PLEASE SEND ALL RESULTS TO:**

<b>Patient Name:</b>		<b>DOB:</b>	
<b>Doctor Name</b>	<b>Address</b>	<b>Telephone</b>	<b>Fax</b>
<b>1.</b>			
<b>2.</b>			
<b>3.</b>			
<b>4.</b>			
<b>5.</b>			
<b>6.</b>			
<b>7.</b>			