Northwell Health®

Authorization for Access to Patient Information - Healthix

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 Northwell Health (including their agents) 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 and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

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 Northwell Health to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for Northwell Health to access my electronic health information through Healthix.

☐ **3. I DENY CONSENT** for Northwell Health to access my electronic health information through Healthix for any purpose, ***even*** *in a medical emergency.*

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.

Patient/Agent/Relative/Guardian* (Signature) Date / Time

Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date / Time

Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time

Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

VD057 (11/1/18)

Northwell Health®

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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(s) 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 & diagnoses
   - Birth control and abortion (family planning)
   - Medication and Dosages
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Diagnostic information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
   - Trauma history summary

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 checking 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 Provider Organization at: 800-894-3226; 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, 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**.**

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Orlin&Cohen Orthopedic Group
An affiliate of Northwell Health

REGISTRATION FORM

Instructions: Fill in the blanks and please replace any incorrect or outdated information

Patient Appointment Information						
Attending Physician	**Scheduled Resource**	**Appt Date**	**Appt Time**	**Encounter #**	**MGMRN #**	**Activity Type**

Patient Information				
Patient Name			**Preferred Name**	
DOB	**Gender**	**Marital Status**	**Marital Status Key** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Address		**City State Zip**	**Email Address**	
Cell Phone	**Preferred Language**		**Preferred Appointment Reminder Method**	
Home Phone	**Ethnicity** **Ethnicity Key** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown		**Race** **Race Key** AIA – Native American Or Alaskan ASN – Asian BAA – African American Or Black DECL – Declined NHP – Native Hawaiian Or Pacific Islander OTH – Other Or Multiracial WHT – White	
Northwell Employee – Yes or No				
Parent 1 Name – *Optional*			**Parent 2 Name – *Optional***	

Contact Information				
Contact Name	**Relationship**	**Contact Type** Emergency	**Preferred Phone**	**Alternate Phone**
Contact Name	**Relationship**	**Contact Type** Next Of Kin	**Preferred Phone**	**Alternate Phone**

Guarantor Information		
Guarantor Name:	**Guarantor DOB**	**Relationship To Patient**
Guarantor Phone	**Guarantor Address**	**City, State, Zip**

Physician Information	
Referring Physician Name	**Referring Physician Phone**
Primary Care Physician Name	**Primary Care Physician Phone**

Insurance Information			
Primary Insurance Name	**Primary Insurance ID#**	**Subscriber Name/DOB**	**Subscriber Relation To Patient**
Primary Insurance Address	**Primary Insurance Group #**		**Primary Insurance Phone #**
Secondary Insurance Name	**Secondary Insurance ID#**	**Subscriber Name/DOB**	**Subscriber Relation To Patient**
Secondary Insurance Address	**Secondary Insurance Group #**		**Secondary Insurance Phone #**

Northwell Health
Physician Partners

Pharmacy Intake Form

Patient Name: _____ Date of Birth: _____

Retail Pharmacy Information *(please complete as much information as possible)*

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone Number: _____

Pharmacy Fax Number: _____

Do you use a Mail Order Pharmacy? *(Circle One)* Yes No

Mail Order Name: _____

Mail Order Address: _____

Mail Order Telephone Number: _____

Mail Order Fax Number: _____

Do you use a pharmacy in addition to the above? *(Circle One)* Yes No

This pharmacy is: ☐ Seasonal ☐ Specialty ☐ Other _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone Number: _____

Pharmacy Fax Number: _____

Northwell Health® Physician Partners

CONTACT CONSENT FORM

Email, Text Messages, and Voicemail

It is important for Northwell Health to be able to communicate with you about your healthcare. If you have provided an email address, cell phone or home phone number, Northwell may use those means of communication to reach out to you about appointment details, office information and limited information about your care. Messages sent through email or SMS text will be limited in the information they contain to protect your privacy. These text messages and emails are not encrypted in transit. To reduce the chance that your information is seen by the wrong recipient, we suggest you enable the highest security measures on your personal devices (passcodes, strong passwords, two step authentication, etc.).

If you DO NOT want Northwell to communicate with you via the email or phone number you provided, please initial below.

☐ DO NOT email me

☐ DO NOT text me

☐ DO NOT leave a voice mail message for me

Northwell will use the cell phone number(s) and/or email address(es) that you provide. It is important for you to keep your contact information with Northwell up to date, and review your email and phone numbers at each visit.

My Care Contacts

☐ Check here if you do not wish for us to speak with anyone but you.

If you would like to authorize Northwell Health to communicate with other individuals about your healthcare, please indicate your communication preferences below.

I give Northwell Health consent to communicate with the following individual(s) about my healthcare (such as appointment details, prescription information, test results).

Name: _____

Relationship: _____

Phone Number: _____

Please see page 2

Northwell Health® Physician Partners

CONTACT CONSENT FORM

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Acknowledgement

By signing below, I understand that Northwell Health has my permission to contact me or my Care Contact(s) identified on this form. I understand that I am responsible for notifying the office staff if there are changes to my designated communication preferences. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where indicated below.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID # **OR**	Date	Time		
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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Orlin&Cohen
Orthopedic Group

Affiliate of Northwell Health

CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

Consent to Treat

I authorize the medical staff, nursing staff and other personnel at this Northwell Health hospitals, Northwell Health Physician Partners ("NHPP") and associated physician locations (collectively, "Northwell',) to provide care, including telehealth services, and to administer such diagnostic, radiological and/or therapeutic procedures and treatments as the medical staff determines is necessary or advisable in my care, or, for obstetrical patients, in the care of my baby. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where indicated below. For a list of NHPP locations, please visit: https://www.northwell.edu/physician-partners/locations.

Assignment of Benefits

I hereby irrevocably assign and transfer to Northwell any monies or benefits to which I may be entitled, including benefits/monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my medical care. I authorize and direct Northwell and its physicians, having treated me, to release to such payers or other third parties who are financially responsible for my medical care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also appoint Northwell as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials and proceed against my insurance company in any action, including legal suit, on my behalf if for any reason my insurance company refuses to pay my claim. The appointment shall include all rights to recover attorney's fees and costs for such action brought by Northwell as my assignee. I further agree to provide information as necessary and to cooperate with Northwell to process and obtain payments.

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release it to the Social Security Administration and Centers for Medicare and Medicaid Services or its

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CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

intermediaries or carriers for the purpose of payment. I request that payment of authorized benefits related to my care be assigned to Northwell.

Guarantee of Payment

I understand that I am financially responsible for charges not covered by insurance. I agree to pay all amounts for which I am responsible for medical services rendered in accordance with the rates and terms of this practice or as determined by my health plan. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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UNDERSTANDING ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

What is an assignment of benefits?

An assignment of benefits is an arrangement where you, the beneficiary, request that your insurance company pay the health benefit payment(s) directly to your health care providers. When you sign the assignment of benefits form, you are essentially entering into a contract with your health care provider to transfer your right of reimbursement from your insurance company to your health care provider. This provides a convenience to both you and your health care provider.

How does this benefit me, the patient?

This arrangement benefits you as a patient because you don't have to pay your health care provider(s), send the bill to your insurance company, and then wait for payment.

What information will be disclosed to my insurance carrier?

In order to process payment for your treatment, your insurance carrier will need certain patient information acquired during the course of your treatment, including, but not limited to any medical records, notes, test results, x-rays, MRI reports, including itemization of any charges and payments on your account.

What if I do not sign the assignment of benefits form?

If you do not sign the assignment of benefits, your health care provider will ask you to pay them directly and you will have to seek reimbursement from your insurance company. If your insurance company denies all or part of your medical bill, you will be responsible for disputing your medical bills. This may include filing an appeal and a review process.

What does guarantee of payment mean?

This means that you are responsible for all payment obligations arising out of your treatment or care. This includes any deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier directly.

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UNDERSTANDING ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

Deductible: The amount you pay for your healthcare services (excluding monthly premiums) before your health insurance begins to pay. For example, if your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your health care services. After you reach $2,000, your health insurance will cover the rest of the cost.

Co-Payment: A fixed amount (for example, $20) you pay to your healthcare provider at the time you receive services. You may have to pay a co-pay for each covered visit to your provider, depending on your plan. The amount can vary by the type of covered health care service.

Co-Insurance: A percent you must pay after you have paid your deductible. This payment is for covered services only. You may still have a co-pay. For example, your plan might cover 80% of your medical bill. You will have to pay the other 20%. The 20% is the co-insurance.

Supplemental Insurance: An additional insurance plan that helps pay for health care costs that are not covered by a person's regular health insurance plan. These costs include copayments, coinsurance and deductibles. There are many different types of supplemental health insurance, including vision, dental, hospital, accident, disability, long-term care and Medicare supplemental plans.

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REGISTRATION FORM - SUPPLEMENTAL INFORMATION

Legal Name: _____ **Date of Birth:** _____

MGMRN #: _____ **Today's date:** _____

Northwell Health is dedicated to providing leading edge care and world-class resources that meet the needs of all of our patients. We strive to break down barriers and offer individualized, compassionate health care to each and every person. The following questions allow us to serve and promote the personal health and wellness of all of our patients.

Gender: What gender appears on your legal identification? Currently: _____

- ☐ Female
- ☐ Male

Birth Sex: What sex appears on your original birth certificate?

- ☐ Female
- ☐ Male
- ☐ Other/Intersex
- ☐ Withheld/Decline to Answer

☐ Same as Above

Gender Identity: What is your current gender identity?

- ☐ Female
- ☐ Male
- ☐ Non-binary/GNC/Genderqueer
- ☐ Transfemale/Male to Female
- ☐ Transmale/Female to Male
- ☐ Various/Other: _____
- ☐ Withheld/Decline to Answer

☐ Same as Above

Please complete the following optional questions:

Name you prefer to identify with:

_____

(last name) (first name) (middle name)

Preferred Pronoun: Which pronoun should we use to refer to you?

- ☐ Her/She
- ☐ Him/He
- ☐ Them/They
- ☐ Various/Other: _____
- ☐ Withheld/Decline to Answer

☐ No Changes

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