Marlene and Paolo Fresco Institute for Parkinson's and Movement Disorders

New Patient Intake Questionnaire

Name: _____ **Appointment Date:** _____

Date of birth: _____ **Handedness:** Right Left Ambidextrous

Who referred you to our center?

Name: _____ Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

Type of Doctor (if relevant): _____

Who is your internist, general doctor, or primary care provider?

Name: _____ Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

Type of Doctor (if relevant): _____

Demographics:

Occupation: _____ Name of employer: _____

Employment status (circle one): Working full time Working part-time Student
Short-term disability Long-term disability Retired

Highest grade level or degree(s): _____

Marital status (circle one): Single Married Separated
Divorced Widowed Domestic Partner

Spouse's/Domestic partner's name (if any): _____

How many children do you have? _____ Who lives at home with you? _____

In which country were you born? _____

Countries of your ancestors? _____

What is the **major neurological problem** that brings you to the office today?

_____

_____

_____

Current Medications, Vitamins, and Supplements:

Please list the medication **name**, **dose,** and **timing**.

Examples: Carbidopa-Levodopa 25/100 mg, 2 tablets 5 times daily at 8-12-2-4-8
Melatonin 3 mg tablets, 1 tablet every evening

Medication:	Supplements:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Are you allergic to any medications, foods, or contrast dye? Yes No

What are you allergic to? What is your reaction? _____

Personal and Social History:

Do you smoke? Yes No When did you start? _____How many packs/day?____

Are you a prior smoker? Yes No When did you quit? _____

How much alcohol do you drink?
Glasses wine/week_____
Number of beers/week_____
Ounces liquor/week_____

How many cups per **week** of caffeinated drinks (i.e. coffee, tea, soda) do you **currently** use:____

Do you **currently** use recreational drugs? Yes No Which one(s)? _____

Have you **ever** used recreational drugs? Yes No Which one(s)? _____

Are you sexually active? Yes No

For women only:
Are you currently use (circle): Birth Control Pills IUD

Are you planning to become pregnant in the next year? Yes No

Age of Menopause: _____ or N/A

Please circle any tasks that you are having difficulty with and/or need help with:

Basic:

Bathing	Toileting	Eating
Dressing	Transferring	Drinking
Personal hygiene	Walking	Other: _____

Instrumental:

Cleaning	Managing finances	Getting to and from appointments
Cooking	Taking medications	Other: _____
Shopping	Using the telephone or computer	

Past Medical and Surgical History:
(If you provided this information online, please skip)

What medical problems do you have (or have you had in the past)?
Please include hospitalizations.

Please list all surgeries or accidents that you have had, and the dates.

Family History (including parents, siblings, children):
(If you provided this information online, please skip)

Name	Relationship	Current Age (or age at death)	Medical problems (and/or cause of death)	Alive (Y/N)?

Dear Patient,

In accordance with HIPPA regulations, we take your privacy very seriously. To help us better protect your confidential information, please complete the form below.

Patient Name	
Date of Birth:	

I authorize the person(s) listed below to communicate with the Fresco Institute physicians and staff regarding the following information pertaining to my medical care:

Initial all that apply:

	Schedule, confirm, cancel my appointment
	Request medication refills
	Discussing any or all of my medical care including evaluations, treatment, diagnosis even if related to psychiatric or psychosocial impairments, pregnancy, substance abuse, acquired immunodeficiency virus (AIDS) or HIV-related opportunistic infection.

Name of the person that you would allow us to release medical information to	**Relationship**	**Telephone No.**

_____ _____

Patient signature Date

NYU Langone MEDICAL CENTER

Faculty Group Practice Patient Demographic Form

Patient Information

Name (Last, First, MI)			Today's Date
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender ☐ Male ☐Female	Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner □ Other
Race	Ethnicity	Preferred Language	Email address

Financially Responsible Party

Is patient responsible party/guarantor? ☐Yes☐No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	

Emergency Contact

Name	Relationship to Patient
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Primary Care Physician's Name (Check if same as Referring Physician above☐)	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company	Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐Female	Date of Birth	Employer of Subscriber	Work Phone ( )
Secondary Insurance Company	Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient):_____ Date: _____/_____/_____

Form Revised: 10/25/2011

NYU Langone HIE, Care Everywhere, and Healthix
Fact Sheet

Details about patient information exchanged through the HIE, Care Everywhere, and Healthix and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by the HIE Participants and Care Everywhere Providers only to:
   - Provide you with medical treatment and related services.
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

Unless otherwise permitted by State and Federal law and if permitted by Healthix, your electronic health information shall be disclosed, accessed and used by NYU Langone Health healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare 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.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all NYU Langone Health patients and members.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included**. If you give consent, the HIE Participants and Care Everywhere Providers may access ALL of your electronic health information available through the HIE and all employees, agents and members of the medical staff of NYU Langone Health System and affiliated entities may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems including, but not limited to, diagnosis, medication, diagnostic information, history and summaries, clinical notes, and discharge summary • Birth control and abortion (family planning)	• Mental health treatment • Allergies • Genetic (inherited) diseases or tests • Sexually transmitted diseases • HIV/AIDS

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from NYU Langone Health System or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the HIE website **http://health-connect.med.nyu.edu/. You can contact the NYU Langone Health Privacy Officer by writing to: NYU Langone Health, Privacy Officer, One Park Ave, 3rd Floor, New York, NY 10016 or by calling 212-404-4079. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.**

4. **Who May Access Information About You, If You Give Consent.** "NYU Langone Health System and affiliates" as used in this consent form includes NYU Langone Hospitals, NYU School of Medicine, the Family Health Centers at NYU Langone, NYU Winthrop Hospital and the NYU Winthrop Medical Affiliates. Only these people from these locations may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE Participant, Healthix Participant or Care Everywhere Provider who are involved in your medical care; health care providers who are covering or on call for an approved HIE Participant or Care Everywhere Provider's doctors; designated staff involved in quality improvement or care management

activities; and staff members of an approved HIE Participant or Care Everywhere Provider who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **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 one of the HIE Participants or Care Everywhere Providers you have approved to access your records; visit the HIE website: http://health-connect.med.nyu.edu/ or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access to information about you has done so through Healthix, call Healthix at: 877-695-4749; or visit Healthix's website: http://www/healthix.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE Participant or Care Everywhere Provider to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The HIE, Healthix and persons, including Care Everywhere Providers, who access this information through these health information exchanges, must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time the HIE ceases operation, or until 50 years after your death, whichever is later.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a new Consent Form and selecting **I DENY CONSENT**. You can get these forms on the HIE website http://health-connect.med.nyu.edu/. Once completed please fax to 917-829-2096 or submit to your provider.

   Note: Organizations, including Care Everywhere Providers, that access your health information through the HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Refusing to Check a Box (make a choice).** Unless you check the **"I DENY CONSENT"** box, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the HIE. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

11. **Risks of Denying Consent**. If you deny consent for HIE Participants and Care Everywhere Providers to access your information through the HIE and Healthix, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Health System Health Information Exchange ("HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU Langone health providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the HIE. In order for a Care Everywhere Provider to know that information may be available through the HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staffs of NYU Langone Health System and affiliated entities to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization, a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Health System and affiliated entities program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling 877-695-4749. Upon request, your provider will print this list for you from this website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology. To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care". You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box ☑ below:

☐ 1. **I GIVE CONSENT** to ALL of the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access ALL of my electronic health information through the HIE and **I GIVE CONSENT** to ALL employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT** to the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access my electronic health information through the HIE and **I DENY CONSENT** to employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the HIE and HEALTHIX. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

_____	_____	_____
Print Name of Patient	Patient's Date of Birth	Date
_____	_____	
Signature of Patient or Patient's Legal Representative	Print Name of Legal Representative and Relationship (if applicable)	

NYU Langone Health
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.

We are Committed to Your Privacy

NYU Langone Health is committed to maintaining the privacy and confidentiality of your health information. We will only use or disclose (share) your health information as described in this Notice. You will be asked to sign an acknowledgement that you have received this Notice.

Who Follows This Notice

This is a joint Notice that is followed by all employees, medical staff, trainees, students, volunteers, and agents of NYU Langone Health at these locations:

- NYU Langone Hospitals (including the NYU Langone Health Home Care)
- NYU Grossman School of Medicine (including our Faculty Group Practices)
- The Family Health Centers at NYU Langone Health
- Southwest Brooklyn Dental Practice

NYU Langone Hospitals and NYU Grossman School of Medicine participate in an Organized Health Care Arrangement ("OHCA") with the following entities:

- Family Health Centers at NYU Langone Health
- The Southwest Brooklyn Dental Practice
- Long Island Community Hospital ("LICH")

Those entities participating in the OHCA may use and share between each other your information to carry out treatment, payment, and health care operations relating to this arrangement.

If NYU Langone Health professionals provide you with treatment or services at other locations, for example at the Manhattan VA Medical Center or Bellevue Hospital Center, the Notice of Privacy Practices you receive there will apply.

Using and Sharing Your Information

This section describes the different ways that we may use and share your information. We will usually contact you for these purposes by phone, but if you have given us your email address or permission to send a text message, we may contact you that way. Communication by text message and email may be unsecure and unencrypted, and by providing us your mobile phone number or email, you authorize NYU Langone Health to communicate with you in this way.

We mainly use and share your information for treatment, payment, and health care operation purposes. This means we use and share your health information:

- with other health care providers who are treating you or with a pharmacy that is filling your prescription;

- with your insurance plan to collect payment for health care services or to get pre-approval for your treatment; and
- to run our business, improve your care, educate our professionals, and evaluate provider performance.

Sometimes we may share your information with our business associates, such as a billing service, who help us with our business operations. All of our business associates must protect the privacy and security of your health information just as we do.

We may also use or share your information to contact you:

- about health-related benefits or services.
- about your upcoming appointments.
- to see if you would like to take part in research projects.
- about fundraising for NYU Langone Health.

You have the right to opt out of receiving fundraising communications. You can do this by contacting the NYU Langone Health Development Office at developmentoffice@nyulangone.org or by phone at 212-404-3640 or toll free at 1-800-422-4483.

If you do not wish to be notified of research projects you may be able to participate in, you can contact research-contact-optout@nyulangone.org or 1-855-777-7858.

Special protections apply if we use or share sensitive health information. This includes HIV-related information, mental health information, alcohol or drug abuse treatment information, or genetic information. For example, under New York State Law, confidential HIV-related information can only be shared with persons allowed to have it by law, or persons you have allowed to have it by signing a specific authorization form. If your treatment involves this information, you may contact the Privacy Officer for further explanation.

We are also allowed, and sometimes required by law, to share your information in other ways. We have to meet certain conditions in the law before we can share your information for the following reasons. Some examples of each include:

- Public health and safety: reporting diseases, births, or deaths; reporting suspected abuse, neglect, or domestic violence; to avoid a serious threat to health or public safety; monitoring product recalls; and reporting information for safety and quality purposes
- Research: analyzing health record projects that have been approved by our institutional review board (IRB) and are of low risk to your privacy; preparing for a research study; studies that only involve decedents' information
- Judicial and administrative proceedings: responding to a court or administrative order
- Workers' compensation and other government requests: workers' compensation claims payment or hearings; health oversight agencies for activities authorized by law; special government functions (military, national security)

- Law enforcement: with a law enforcement official to identify or find a suspect or missing person
- Comply with the law: to the Department of Health and Human Services to see if we are complying with federal privacy law
- Disaster relief situation: sharing your location and general location for the purpose of notifying your family, friends, and agencies chartered by law to assist in emergency situations
- To organizations that handle organ, tissue, or eye donation or transplantation
- To a coroner, medical examiner, or funeral director as needed to do their jobs
- Incidental to a permitted use or disclosure: calling your name in a waiting area for an appointment and others in the waiting area may hear your name called. We make reasonable efforts to limit these incidental uses and disclosures.

In the following situations, we may use or share your information, unless you object or if you specifically give us permission. If for some reason you are not able to tell us your preferences, for example if you are unconscious, we may share your information if we believe it is in your best interest.

- For our patient directory, including to our chaplaincy services department, such as a priest or rabbi.
- With your family, friends, or others involved in your care or payment for your care.

In the following situations, we will only use or share your information if you give us written permission:

- For marketing purposes
- Sale of your information or payments from a third party
- Most sharing of psychotherapy notes
- Any other reasons not described in this Notice

You can revoke (take back) that permission, except when we have already relied on it, by contacting the Privacy Officer.

Your Rights

When it comes to your health information, you have certain rights. You may:

- Review or get an electronic or paper copy of your medical record, including billing records. You may be charged a reasonable cost based fee for your records. We will let you know about any delay. You can also access your health information directly using our secure patient portal, NYU Langone Health MyChart at https://mychart.nyulmc.org/.
- Request confidential communications. You can ask us to contact you in a certain way, for example, by cell phone. We will say “yes” to all reasonable requests.
- Ask us to limit what we use or share for your treatment, payment, and healthcare operations. We are not required to agree to your request, but we will review it. When you pay for services out-of-pocket, in full, and ask us not to share the information with your insurance plan, we will agree unless a law requires us to share that information.

- Ask us to correct your medical record if it is inaccurate or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
- Get a list of those with whom we have shared information. You can ask for a list (accounting) of the times we shared your information and why for the six years prior to your request. Not all disclosures will be included in this list, such as those made for treatment, payment, or health care operations. You have the right to get this list one time every 12 months without charge, but we may charge you for the cost of providing additional lists during that time.
- Get a copy of this privacy Notice. Just ask us and we will give you a copy in the format you would like (paper or electronic).
- Choose someone to act for you. This "personal representative" can exercise your rights and make choices about your health information. Generally, parents and guardians of minors will have this right for the child, unless the minor is permitted by law to act on their own behalf.
- File a complaint if you feel your rights have been violated. You may contact the Privacy Officer or the Secretary of the United States Department of Health and Human Services. We will not retaliate or take action against you for filing a complaint.
- Request additional privacy protections with respect to your electronic medical record.

Our Responsibilities

- We are required by law to maintain the privacy of your protected health information.
- We will notify you if a breach occurs that may have compromised the privacy or security of your identifiable information.
- We must follow the practices described in this Notice and give you a copy of it.
- We reserve the right to change the terms of this Notice and the changes will apply to all information we have about you. The new Notice will be available upon request and on our website at www.nyulangone.org.

Questions or Concerns

If you have a question or wish to exercise your rights described in this Notice, please contact the Privacy Officer at: One Park Avenue, 3rd Floor, New York, New York 10016, Attention: Privacy Officer, by phone to 1-877-PHI-LOSS or 212-404-4079, or via email to compliancehelp@nyulangone.org.

Most requests to exercise your rights must be made in writing to the Privacy Officer or the appropriate doctor's office or hospital department. For more information or to get a request form, contact the Privacy Officer or visit http://nyulangone.org/policies-disclaimers/hipaa-patient-privacy.

This Notice is effective as of 9/1/2022.

NYU Langone Health
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

By signing this form, I acknowledge that I have received a copy of NYU Langone Health's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ **Date:** _____

Personal Representative's Name (if applicable): _____

Personal Representative's Authority (e.g., parent, guardian, health care proxy):

_____

Effective as of 9/1/22.

NYU Langone Health

FACULTY GROUP PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

I understand that NYU School of Medicine, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

- **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

    - My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such a referral or I receive services in excess of the referral, and/or
    - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
    - I have chosen not to use my health plan coverage, and/or
    - The physician I see does not participate with my health care plan.

- **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number_____**Patient Signature** _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.

- **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have been provided the Faculty Group Practice Patient Financial Policies. I understand the information listed above which has been fully explained to me.

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature **Date**

Form Revised: 9/14/2016

Summary of Faculty Group Practice Financial Policies

Thank you for choosing NYU Langone Medical Center for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of- pocket fees, and coverage limits.

PLEASE KEEP THESE POLICIES FOR FUTURE REFERENCE

Insurance Coverage
Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Our doctors belong to many insurance plans but participation differs by doctor. You can see a list of plans that our physicians participate with on our website (http://nyulangone.org/doctors). Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. If you would like a cost estimate, we would be happy to provide one. We will also help you find out if you have out-of-network benefits. Refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim to your plan.

Address Change
It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments/Co-insurances/Deductibles
You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.

Other Bills
You may receive services at NYU Langone Medical Center such as anesthesia, radiology testing, pathology, or other services. These doctors provide vital services and are involved in your care even though they may not be present at the time and you may not see them face-to-face. There may be additional charges for these services.

In addition, you may receive in-patient or out-patient hospital care at NYU Langone Medical Center. If so, you will receive a hospital bill for those services. Hospital bills are separate from our doctor services. If you have questions, you may contact the hospital billing office at (800) 237-6977.

Payments
Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card *(American Express, MasterCard, Visa and Discover)*. Returned checks are subject to a fee of $20.00. We do not accept traveler's checks.

As a service to our clients, we provide a courtesy [bill pay reminder] call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Non-Medical Fees
Additional fees may apply to the following:

- Returned Checks
- Completion of disability or other forms
- Copying of medical records

Missed Appointments
Generally, NYU FGP requires a 24 hour (1 business day) cancellation notice for most office visits. Procedures and surgeries may require 48 hours (2 business days) or more. Please note that weekends and holidays are not considered business days. If you miss your appointment, or do not cancel with the required notice, additional fees may apply:

- Office Visit: $50
- Second Office Visit $75
- New Patient Visit: $75
- Procedure/Surgery Per Dept Policy

Out-of Network Providers
If the doctor is not in your insurance plan, the following apply:

- Full payment is due at the time of service for routine visits.
- Payment expected on the date of service may be an estimate of your total charges.
- You will be quoted an estimated fee before services/procedures are performed.
- A deposit is required prior to the date of service for elective surgeries and procedures.
- Even if you have out-of-network benefits, you are ultimately responsible for the full fee charged.
- Depending on your plan, payment may be sent to you. If you receive this payment, you must reimburse NYU Faculty Group Practice immediately.

Non-Covered Services
Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.
Non-Medicare Patients. Any service not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds
All credit balances will automatically be applied to any open balance on your account, including any amounts owed to other NYU Faculty Group Practice providers. A refund is issued (less any outstanding balances) when an overpayment has been identified. If you feel a refund is due and you have not received one, please contact our billing office at (877) 648-2964.

Failure to Pay
If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our Managers for more details or call the billing office at the number listed on your billing statement.

FACULTY GROUP PRACTICE LABORATORY BILLING INFORMATION

Thank you for choosing NYU Langone Medical Center Faculty Group Practice for your medical care. Any laboratory services or specimens provided by NYU are sent to the NYU Langone Medical Center outpatient laboratory for processing. The outpatient laboratory is a hospital service that is billed separately from your physician visit. The NYU Langone Medical Center laboratory participates with most insurance plans; however some plans have a specific laboratory facility preference. You should review your laboratory plan to understand your benefits as services provided may be subjected to hospital coinsurances and deductibles. It is your responsibility to understand your insurance plan benefits and to notify our staff or physicians of your preferred laboratory at each visit. Based on your request we will send your specimen to the laboratory your choice.

Should you have questions our practice staff will either answer your question or direct you to your insurance carrier.

Revised: 10-25-11

NYU Langone
MEDICAL CENTER

Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.
**Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU laboratory.**

LabCorp	
Quest Labs	
NYU Lab	
Sunrise Laboratory	
Other External Location	

Please provide name of external location: _____

FACULTY GROUP PRACTICE CELL PHONE CONTACT FORM

I understand that as a service to its patients, NYU Langone (Faculty Group Practice) provides bill pay reminders to patients that may be placed using a prerecorded message or text message. By providing my cell phone number to NYU Langone and signing below, I am giving consent to receive these calls or text messages at the number maintained in my NYU Langone medical record. I understand that if my cell phone number is updated at NYU Langone, I will receive the calls or text messages to the new number, unless I have opted out as described below. I also understand that this consent will apply to any NYU Langone Faculty Group Practice office that may use this service.

☐ **I GIVE CONSENT for NYU Langone to contact me regarding bill pay reminders on my cell phone.**

☐ **I DENY CONSENT for NYU Langone to contact me regarding bill pay reminders on my cell phone.**

I understand that I can opt-out at any time by emailing my name and date of birth (for verification) to NYUPhysicianServices@nyumc.org, submitting a message via MyChart, or by providing written notice to: NYU Langone Physician Services, PO Box 415662, Boston, MA 02241

_____ _____

Patient (Parent/Guardian) Signature **Date**

Revised 5/23/18