NYU Langone MEDICAL CENTER

Faculty Group Practice Patient Demographic Form

Patient Information

Name (Last, First, MI)			Email address	
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	Country of Origin	

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: 7/25/2012

NYU Langone
MEDICAL CENTER

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: 6/1/2013

NYU Langone Medical Center
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I have received a copy of NYU Langone Medical Center's Notice of Privacy Practices.

By providing my email address, I consent (agree) to receiving notifications, including breach notifications, through the Medical Center's secure email messaging system.

Patient Name: _____

Personal Representative Name (if applicable): _____

Personal Representative's Authority (ex: parent, guardian, health care proxy): _____

_____

Email Address: _____

Signature: _____ **Date:** _____

Effective as of 05/23/2013.

NYU LANGONE MEDICAL CENTER

NYU Hospitals Center and NYU School of Medicine
Consent for Electronic Health
Information System

I have received the NYU Langone Medical Center Electronic Health Information System Fact Sheet. It describes (1) the purpose of the NYU Langone Medical Center Electronic Health Information System; (2) how it works; and (3) how the providers participating in the NYU Langone Medical Center Electronic Health Information System will record and access my health information.

I acknowledge receipt of the Electronic Health Information System Fact Sheet. I have read and understand the Fact Sheet.

I also understand that by signing this form, I am agreeing to permit all NYULMC providers directly involved in my care to create, access, use and/or share my health information (including my electronic prescription records) for treatment, payment and healthcare operations and, to permit my health information to be available to my other health care providers, all as described in the attached Electronic Health Information Fact Sheet.

I also understand that there are other uses and disclosures of Protected Health Information that are permitted under applicable law and are outlined in the Notice of Privacy Practices.

I understand that this consent will remain in effect unless revoked in writing. Upon revocation, I understand that, except in an emergency, I can no longer be treated at NYU Langone Medical Center or by NYU providers who use the NYULMC EHR in their office practice.

Signature: _____ Date: _____ Time: _____ AM/PM
(Patient or person authorized to sign)
If the consenting party is other than the patient, print name and relation to patient:
_____

(Rev. 07/13)

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 Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care 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 NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC 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 electronically 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 staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), 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 Medical Center 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 Healthix at 877-695-4749**.** Upon request, your provider will print this list for you from the Healthix 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 NYULMC 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 (health IT). 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 Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center 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 ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **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 NYULMC HIE. 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 Date of Birth
_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

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	
Other External Location	

Please provide name of external location: _____

NYU Vein Center ♦ 530 First Avenue, Suite 6D ♦ New York NY 10016 **(Required for Pre-Certification of Services)**

Patient Name _____ Date of Birth _____

List any allergies _____ List current medications:_____

Your insurance carrier (including Medicare) may require a minimum of at least 3-6 months of "conservative, non-operative treatment" in order for them to pre-approve/make payment for your services. The insurance carriers define "conservative, non-operative treatment" to include: "Mild exercise, periodic leg elevation, weight loss, compressive therapy (stockings), and avoidance of prolonged inactivity".** Please take your time to fill out this questionnaire. **

1. Social History: Smoke? ☐ **YES** ____#Packs/day **NO** ☐ Alcohol? ☐ **YES** # per day/week _____ **NO** ☐

2. Have you had any prior treatment for varicose/spider veins? ☐ **YES** **NO** ☐

   Describe _____ Date (s) of treatment _____Surgery Dates_____
   Type of agent (s) used, if known _____

3. Do you have a history of ulcerations, chronic swelling of your legs, or clots? When?_____ ☐ **YES** **NO** ☐

4. Do you have a family history of varicose/spider veins? If yes, relationship (s) to you _____ ☐ **YES** **NO** ☐

5. Are you currently, or have been, on any hormone therapy or birth control pills? ☐ **YES** **NO** ☐
   If yes, please list _____

6. Have you had any pregnancies? _____ If yes, how many children do you have?_____ ☐ **YES** **NO** ☐
   If yes, did your varicose/spider veins increase after your pregnancy? ☐ **YES** **NO** ☐

7. Have you worn support hose? More than 6months? ___ # months worn_____ # years worn_____ ☐ **YES** **NO** ☐

8. Are you presently employed? If yes, type of job _____ ☐ **YES** **NO** ☐

9. Do you sit or stand for long periods of time? Hours per day? Sitting ____hours Standing _____hours ☐ **YES** **NO** ☐

10. **Please describe how your condition/discomfort LIMITS/IMPACTS your daily activity"? Frequency/ timing of discomfort/pain?

_____

_____

_____(please use reverse side if necessary)

11. Have you taken any pain medication for you varicose/spider veins? _____# months _____#years ☐ **YES** **NO** ☐
    (Including Aspirin, Tylenol, Motrin IB, Advil, etc.) If yes, please list _____

12. Do you elevate your legs to relieve your symptoms? ____hours/day , # months____, # years_____ ☐ **YES** **NO** ☐
    If yes, does it help? ☐ Temporarily ☐ **YES** **NO** ☐

13. Are you presently on a weight loss/weight management routine? _____# months ☐ **YES** **NO** ☐

14. Do you exercise? ☐ Mild/Occasional ☐ Regular Regiment ☐ Intense workout # months_____ ☐ **YES** **NO** ☐

PLEASE CHECK ALL THAT APPLY:

	RIGHT LEG	LEFT LEG
Edema (swelling)		
Pain (Mild, moderate, severe)		
Tiredness, Throbbing, Achiness		
Ulceration		
Skin color changes		
Spider veins		
Varicose veins		

Patient Signature _____ Date _____ Nurse Initials_____ M.D. Signature_____

NYU Vein Center ♦ 530 First Avenue, Suite 6D ♦ New York NY 10016

REVIEW of SYSTEMS

Patient Name (print): _____ **Date:** _____

Reason for Visit :_____

Height_____ **Weight**_____

CONSTITUTIONAL SYMPTOMS		
Good general health lately	no	yes
Recent weight change	no	yes
Fever/fatigue	no	yes
Headaches	no	yes
CARDIOVASCULAR		
History of heart attack	no	yes
History of stroke	no	yes
Heart murmur (s)	no	yes
History of hypertension	no	yes
History of chest pain/CHF	no	yes
History of phlebitis/blood clots	no	yes
Do you have a pacemaker	no	yes
Shortness of breath w/ walking/lying flat	no	yes
Swelling of legs/ankles	no	yes
RESPIRATORY		
Chronic or frequent coughs	no	yes
Spitting up blood	no	yes
Asthma or wheezing	no	yes
Chronic Lung Conditions	no	yes
Tuberculosis	no	yes
GASTROINTESTINAL		
Loss of appetite	no	yes
Heartburn/abdominal pain	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Rectal bleeding/blood in stool	no	yes
Peptic ulcer (stomach or duodenal)	no	yes
MUSCULOSKELETAL		
Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles/joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Pain with walking	no	yes
INTEGUMENTARY		
Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose Veins	no	yes
Leg ulcers	no	yes
OTHER		
History of Cancer	no	yes
Type of cancer:_____		
Chemotherapy/Radiation	no	yes

Past Surgeries:_____

_____

_____

_____

NEUROLOGICAL		
Frequent or recurring headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness/tingling	no	yes
Tremors	no	yes
Paralysis	no	yes
Stroke	no	yes
Head injury	no	yes
Difficulty w/balance	no	yes
ENDOCRINE		
Glandular/hormone problem	no	yes
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst/urination	no	yes
Heat/cold intolerance	no	yes
Do you take Glucophage	no	yes
Skin becoming dryer	no	yes
Hematologic/Lymphatic		
Slow to heal after cuts	no	yes
Bleeding or bruising tendency	no	yes
Anemia	no	yes
History of phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes
Blood borne disease	no	yes
GENITOURINARY		
Renal disease/dialysis	no	yes
Difficulty w/ urination	no	yes
Frequent/burning urination	no	yes
Incontinence	no	yes
Blood in urine	no	yes
Menses/vaginal bleeding/pain	no	yes
Testicular/prostate problems	no	yes
Allergic/Immunologic		
History of skin reaction/adverse reaction	no	yes
Penicillin or other antibiotics	no	yes
Iodine, methiolate or other antiseptic	no	yes
Do you take coumadin, aspirin or other blood thinners	no	yes
Do you smoke?	no	yes
How much?_____		
Do you drink?	no	yes
How much?_____		

Allergies: _____

Current Medications:

_____

_____

_____

_____

Physician Signature_____