THE HUNTINGTON HEART CENTER

172 EAST MAIN STREET · HUNTINGTON, N.Y. 11743
Tel: (631) 385-0022 • Fax: (631) 385-0896

PATIENT REGISTRATION

Name:_____ Sex:_____ DOB:_____

Address:_____ City:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

E-mail address:_____

** BILLING STATEMENTS WILL BE E-MAILED TO THIS ADDRESS GIVEN **

Social Security #: ___-___-___ Primary Care Physician:_____

Emergency Contact: _____ Phone #: ( )_____

INSURANCE INFORMATION

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____ ID#: _____

Name of Insured:_____ DOB:_____

I understand that I will be held liable for payment of all services rendered to me by my physician at the Huntington Heart Center if I have provided incorrect insurance information which results in non-payment on any date of service. I understand there are cancellation & a no show charge of $25 if I do not inform the office within 24 hours of my appointment. The fee for cancellation & no show for Thallium Stress Test is $200 and the fee for PET scans is $500, unless there is an emergency.

Patient Signature: _____ **Date:**_____

Uses and Disclosures Requiring Your Written Authorization

- Use or Disclosure with Your Authorization. For any purpose other than the ones described above, we may only use or disclose your PHI when you grant us your written authorization on our authorization form.

- Marketing. We must also obtain your written authorization prior to using your PHI to send you any marketing materials.

- Special Authorization. Confidential HIV-related information, psychotherapy notes, or substance/alcohol abuse information will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances as required by law.

Your Rights Regarding Your Protected Health Information

- Right to Access Your Protected Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office.

- Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI for treatment, payment and health care operations, or to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy Officer and submit the completed form to the Privacy Officer. We will send you a written response.

- Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

- Right to Revoke Your Authorization. You may revoke your Authorization except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.

- You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services.

- Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

- Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003.

- Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

- For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with us or the Director.

Effective Date and Duration of This Notice

- Effective Date. This Notice is effective on January 1, 2009.

- Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around the Practice. You also may obtain any new notice by contacting the Privacy Office.

Privacy Officer

- You may contact the Privacy Office at:
  Privacy Officer – Marion Henken
  The Huntington Heart Center
  172 East Main Street
  Huntington, NY 11743
  Telephone Number: (631) 385-0022

Acknowledgment

By signing below, I acknowledge that I have been provided a copy of the Practice's Notice of Privacy Practices (the "Notice") and have therefore been advised of how health information about me may be used and disclosed by the Practice and how I may obtain access to and control this information. I also acknowledge that the Practice may use and disclose my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Practice, its staff.

X _____ X Date: _____

Signature of patient or
Patient's representative

Raj Patcha M.D.,P.C.,F.A.C.C, F.C.C.P., F.S.C.A.I.
Marco Papaleo M.D.,F.A.C.C
Sotir Polena M.D.,F.S.C.A.I.,F.A.C.C
Adam Davis, D.O.
Antonio Moretta, M.D.

The Huntington Heart Center

172 East Main Street
Huntington, NY 11743
(P) 631-385-0022 (F) 631-385-0896

Last Name:_____ First Name:_____ DOB:_____/____/_____

I, _____, (___do/____do not) give permission for any staff member of the **HUNTINGTON HEART CENTER and its Physicians,** to speak with a family member or individual regarding appointments, prescriptions, financial matters, test results, or pick up films on your behalf. Please list the individuals that we may speak with:

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____

May we leave a voicemail recording regarding your appointment or a message to call us back?

☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION VIA EMAIL

By providing your email address, you agree to receive information about your protected health information as well as upcoming appointments that are scheduled.

☐ Yes ☐ No

AUTHORIZATION TO ACCESS PRESCRIPTION HISTORY

I hereby authorize my physician(s), to download my prescription history through computer networks operated by Surescipts Clearinghouse, a provider of electronic prescribing services, in connection with providing me health care services.

☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

I hereby authorize and direct my physician(s), having treated me, to release to other treating physicians, government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer, and set over to my physician(s), sufficient monies and/or benefits I may be entitled from government agencies, insurance carriers, or others who are financially liable for medical costs of the care and treatment rendered to me or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

_____ _____
Patient Signature Date

I have read and understood the HIPAA NOTICE OF PRIVACY PRACTICES of the Huntington Heart Center. I understand how the practice will handle my personal health information.

_____ _____
Patient Signature **Date**