INTERBORO
SURGICAL ASSOCIATES

DEMOGRAPHICS: Please complete this form in its entirety.

NAME: _____ **DATE OF BIRTH:** _____

AGE: _____ **SEX: MALE FEMALE** **MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED**

ADDRESS: _____ **APT:** _____

CITY/STATE/ZIP: _____

SOCIAL SECURITY NUMBER: _____

CONTACT INFORMATION:

HOME (_____) _____-_____ CELL (_____) _____-_____ WORK (_____) _____-_____

EMAIL ADDRESS: _____@_____

EMERGENCY CONTACT:

NAME: _____ **RELATION:** _____

HOME (_____) _____-_____ CELL (_____) _____-_____ WORK (_____) _____-_____

INSURANCE INFORMATION (Please present your insurance card(s) to front desk)

PRIMARY : _____ **POLICY ID #** _____

SECONDARY: _____ **POLICY ID #** _____

PRIMARY CARE PHYSICIAN:

NAME: _____ **PHONE:** _____

ADDRESS: _____

PERSONAL/SOCIAL HISTORY: Please answer YES or NO to the following questions and explain where needed.

Do you have children?	YES	NO	
Do you live alone?	YES	NO	
Are you employed?	YES	NO	If yes, what is your occupation? _____
Are you retired?	YES	NO	If yes, what was your occupation? _____
Do you smoke?	YES	NO	If yes, how often? _____
			If you quit, when? _____
Any occupational hazard?	YES	NO	If yes, what? _____
Any exposure to asbestos?	YES	NO	If yes, when? _____
Do you drink?	YES	NO	If so, how often? _____
Do you exercise regularly?	YES	NO	If yes, how often? _____
Is your weight stable?	YES	NO	

PATIENT SIGNATURE: _____ **DATE:** _____

FAMILY HISTORY: **Please answer YES or NO if you have a family history of the following.**

Aneurysm	**YES**	**NO**	**Relative:** _____	
Cancer	**YES**	**NO**	**Relative:** _____	**Type:** _____
Diabetes	**YES**	**NO**	**Relative:** _____	
Heart Attack	**YES**	**NO**	**Relative:** _____	
Stroke	**YES**	**NO**	**Relative:** _____	
Other: _____			**Relative:** _____	

MEDICAL HISTORY: **Please answer YES or NO to the following and explain where applicable. DO NOT LEAVE BLANK.**

Asthma	**YES**	**NO**	**Bleeding or Bruising Tendency**	**YES**	**NO**
Breathing Problems	**YES**	**NO**	**Burning/Numbness in Hands/Feet**	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	**Weight Loss**	**YES**	**NO**
High Cholesterol	**YES**	**NO**	**Chest Pains**	**YES**	**NO**
Blood Clots	**YES**	**NO**	**Constipation**	**YES**	**NO**
Diabetes	**YES**	**NO**	**Intestinal Bleeding**	**YES**	**NO**
Diarrhea	**YES**	**NO**	**Difficulty Walking**	**YES**	**NO**
Diverticulitis	**YES**	**NO**	**Pulmonary Embolus or Clot**	**YES**	**NO**
Gallbladder Problems	**YES**	**NO**	**Heart Failure**	**YES**	**NO**
Irregular Heartbeat	**YES**	**NO**	**Heart Palpitations**	**YES**	**NO**
Kidney Disease	**YES**	**NO**	**Loss of appetite within the last year**	**YES**	**NO**
Nausea/Vomiting	**YES**	**NO**	**Shortness of Breath with Exertion**	**YES**	**NO**

Have you had any of the following? Please answer YES or NO and explain where necessary.

Cancer	**YES**	**NO**	**Where/When?** _____
Chemotherapy	**YES**	**NO**	**Where/When?** _____
Radiation	**YES**	**NO**	**Where/When?** _____
Stroke	**YES**	**NO**	**When?** _____
Heart Attack	**YES**	**NO**	**When?** _____
Stress Test	**YES**	**NO**	**Where/When?** _____
Heart Surgery	**YES**	**NO**	**Where/When?** _____
Cardiac Catheter	**YES**	**NO**	**Where/When?** _____
Swelling	**YES**	**NO**	**Where?** _____
Implanted Devices	**YES**	**NO**	**What/When?** _____

SURGERY	**DATE**

MEDICATION	**DOSE**	**MEDICATION**	**DOSE**

ALLERGY	**REACTION**	**ALLERGY**	**REACTION**

PATIENT SIGNATURE: _____ **DATE:** _____

Authorization To Use or Disclose Health Information

Patient Name: _____ DOB: _____

I authorize the release of any required medical documents to the below named physician's office:

Interboro Surgical Associates, P.C.
8318 4th Avenue
Brooklyn, NY 11209

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care
- I may revoke this authorization at any time before the information I have requested is released by completing a "Request to Revoke An Authorization" form, which is available at this office
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Interboro Surgical Associates, P.C. shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements
- I may request a copy of this signed form
- Interboro Surgical Associates, P.C. may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment

_____ _____

Patient/Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print name **Relationship to patient**

HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Interboro Surgical Associates, P.C. and its employees, and how I may obtain access to and control this information.

_____ _____

Print Patient Name Date

_____

Parent or Authorized Representative

_____

Patient Signature

Individuals involved in care with which we may share your health information:

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone: _____ Phone: _____

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.

This Notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding such medical information. We are required by law to make sure that medical information which identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your medical information; and follow the terms of the Notice that is currently in effect.

This Notice covers the physician practices of Interboro Surgical Associates, P.C., and its subsidiaries (collectively "Interboro Surgical", "we" or "us"), including its employed physicians and other personnel. (If you are being treated by a Interboro Surgical Associates, P.C. physician while in another institution, you should refer to that other institution's Notice of Privacy Practices for information about how your medical information may be used and disclosed and whom to contact to exercise your rights).

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students,or other Interboro Surgical Associates, P.C. personnel or personnel of New York-Presbyterian Hospital or Columbia University Health Sciences (collectively "our Affiliated Institutions"), who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes**,** because diabetes may slow the healing process. Different departments of Interboro Surgical Associates, P.C. and our Affiliated Institutions also may share medical information about you, such as prescriptions, lab work and x-rays, to coordinate your treatment. We also may disclose medical information about you to people outside Interboro Surgical Associates, P.C. who may be involved in your medical care.

Payment. We may use and disclose medical information about you so that we may bill for treatment and services you receive at Interboro Surgical Associates, P.C. and can collect payment from you, an insurance company or another party. For example, we may need to give information about surgery you received or are going to receive to your health plan so that the plan will pay us or reimburse you for the surgery. In the event a bill is overdue, we may need to give information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies. We may also disclose information about you to our Affiliated Institutions and other healthcare facilities for purposes of payment as permitted by law.

Health Care Operations. We may use and disclose medical information about you for operations of Interboro Surgical Associates, P.C. and our joint operations with our Affiliated Institutions. These uses and disclosures are necessary to run Interboro Surgical Associates, P.C. or such joint operations and make sure that all of our patients receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, medical students, and other Interboro Surgical Associates, P.C. personnel for educational purposes. We may also disclose information about you to other healthcare facilities as permitted by law.

Appointment Reminders; Treatment Alternatives; Health-Related Benefits and Services. We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. We may also tell your family or friends your condition. If you do not wish us to share this information with your friends and family, please follow the procedures described in the Right to Request Restrictions section of this Notice below. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process before your medical information may be used or disclosed. We may use or disclose medical information about you to researchers who are preparing to conduct a research study, for example, to help them look for patients with specific medical needs who might be asked to participate in this project. In this case, information they review will not leave Interboro Surgical Associates, P.C. or our Affiliated Institutions. When legally required, we will ask for your specific written permission (authorization) if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at Interboro Surgical Associates, P.C. or our Affiliated Institutions. Finally, we may permit are searcher to look at your medical information and use and disclose it for research purposes if, after going through an approval process, an evaluation is made that the proposed use and disclosure complies with legal and ethical requirements regarding the privacy of medical information.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Special Privacy Protections. If your medical information includes HIV-related information, alcohol or substance abuse, mental health or genetic information, special protections may apply to such information, and you can contact the Privacy Officer if you have any questions.

To Avert a Serious Threat to Health or Safety. of you, the public or another person, we may use or disclose medical information about you.
Organ and Tissue Donation. If you are an organ or tissue donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

Military and Veterans. If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose to authorize public health or government officials medical information about you for public health activities when required or authorized by law. These activities generally include the following: to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or service; to prevent or control disease, injury or disability; to report disease or injury; to report births and deaths; to report reactions to medications and food or problems with products; to notify people of recalls or replacements of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

may also disclose medical information about you in response to a subpoena, discovery request, or other legal demand by someone else involved in the dispute, but only if efforts have been made by us or someone else to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement/National Security/Protective Services. We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on the premises of Interboro Surgical Associates, P.C.; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; to authorized federal officials so they may provide protection for the President and other authorized persons, or conduct special investigations, or for intelligence, counterintelligence, and any other national security activities authorized by law.

Coroners, Medical Examiners and Funeral Directors. We may release medical information about deceased persons to a coroner, medical examiner or funeral director so they can carry out their duties.

Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made with your written authorization, on a Interboro Surgical Associates, P.C. authorization form. You may revoke such an authorization by writing to the Privacy Officer, and such revocation will be effective to the extent that we have not already released the information pursuant to the authorization or otherwise taken action in reliance on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. This right does not include: psychotherapy notes; information compiled for use in a legal proceeding; or certain information maintained by laboratories.
In order to inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at the address listed at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing to the Privacy Officer that the denial be reviewed. A licensed healthcare professional who was not directly involved in the original decision to deny access will conduct the review. We will comply with the outcome of the review.

Right to Request Amendments. If you think that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address listed at the end of this Notice. In addition, you must give a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for Interboro Surgical Associates, P.C.;
- is not part of the information you would be permitted to inspect and copy; or is accurate and complete.

We will provide you with written notice of action we take in response to your request for an amendment.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we have made of medical information about you. We are not required to account for any disclosures you specifically requested or for disclosures related to treatment, payment, or healthcare operations, made pursuant to an authorization signed by you, or and which fall into certain other limited categories of disclosures.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address listed at the end of this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. You may request one accounting in any 12-month period free of charge, and we will charge you for any subsequent request in the same 12-month period. Such charge may include reasonable retrieval, list preparation, and mailing costs.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. If you wish to request such a restriction, you must contact the Privacy Officer in writing at the address listed at the end of this Notice.

We are not required to agree to your request. If we agree to your request, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must contact the Privacy Officer in writing at the address listed at the end of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will attempt to accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may obtain a copy from any of our Interboro Surgical Associates, P.C. locations or by contacting the Privacy Officer. You may also obtain a copy of this Notice electronically at our website address noted below.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we receive in the future. The current Notice in effect at any time will be posted on our website address listed below and will be available from the Privacy Officer as well as at any of our practice locations.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with Interboro Surgical Associates, P.C. or with the Secretary of the Department of Health and Human Services. To file a complaint with Interboro Surgical Associates, P.C., please call or write to the Privacy Officer at the address listed at the end of this Notice. You will not be penalized or retaliated against for filing a complaint.