Padma Sripada MD, Columbia Internal Medicine
2500 Pond View, Suite 202 Castleton on Hudson, NY 12033 Phone: 518-391-2889

Patient Registration Form

Date: .....

First Name .....Middle.....Last Name.....Sex: M F

Preferred name: "....." Preferred Language.....

Date of Birth ....Birth Place ..... Ethnicity.....

Street Address..... Town .....ZIP Code.....

Home # ..... Cell# .....Work# .....

E-mail ID.....

Social Security #..... Occupation.....

Employer Name/Address.....

Pharmacy Name .....Phone#.....

Family Marital Status: Single Married Divorced Widow Significant other (Name) .....

Spouse's Name .....Date of Birth .... Number of Children: ...

Spouse's Employer Name and Phone# .....

Emergency Contact Name: ..... Ph. #.....

Insurance: Name of the Insured person.....DOB .....

Name of Insurance ..... ID# .....

How did you know about our practice?

Family/Friends Advertiser newspaper Internet Insurance

Other (specify) .....

What did you like about our practice? ....

Our Office Policies

- All refills will be given at the time off an office visit only. Medications will not be called between office visits.
- Missing an appointment without notice (No-show) or cancellation with less than 24-hour notice may incur surcharge up to $50. Multiple No-shows will lead to discharge from the practice.
- Co-pay not paid at the time of service may incur a surcharge of $5.
- Balances on accounts not paid in a timely manner may be turned over to a collection agency. There will be a charge for all costs associated with this action including the collection fees.
- It is the patient's responsibility to call their insurance company to make sure our physician is in their network to avoid any additional charges or fees.

Medical Information

Chief Complaint.....

Medications/Dosage

Present.....

.....

Past year.....

.....

Are you Allergic to or intolerant of any drugs? If yes, please list the drugs and your reaction

.....

Operations/dates.....

.....

Other Major Illnesses and Hospitalizations

.....

.....

.....

Do you smoke? .....Packs/Day.....Did you smoke? ..... Date stopped? .....

How often do you have a drink (Beer, Wine, Liquor?) .....

Have you ever had any problems related to alcohol? .....

If there is any history of following in either yourself or immediate family, please note below:

Alcoholism.....High Cholesterol.....

Arthritis ....Kidney disease.....

Asthma.....Mental illness.....

Cancer..... Osteoporosis.....

Diabetes.....Stroke.....

Heart disease..... Tuberculosis.....

High blood pressure.....

Privacy

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Send your medical information to your personal E-mail?	Yes	No
Discuss your medical condition with a member of your household?	Yes	No

If yes, Name: ..... Relationship: .....

We encourage you to register for secure e-mail through our website: doctorpadma.com to receive our messages, test reports and more.

Consent to treat and assignment of benefits/ authorization to release information:

I consent to treatment necessary for the care of the patient name on this document. I authorized Columbia Internal Medicine LLC to submit claims to my insurance carrier and release any information needed for the processing of claims related to medical services rendered. I allow for release of my personal health information according to HIPPA law for the treatment, payment and operations. I authorized assignment of benefits for physician and lab services to Columbia Internal Medicine LLC. A copy of the signature is as valid as the original. I understand that I am financially responsible for any services not covered by my insurance carriers.

The information I have provided on this registration form is true to the best of my knowledge. I acknowledge that I have received, read and understand the financial and office policies of Columbia Internal Medicine.

Patient (Please print) .....

Signature.....Date.....

Parent/Guardian (Please print).....

Signature.....Date.....

Additions/ Changes/ Comments (If any)

The Patient -Centered Medical Home

The Provider – Patient Agreement

Synopsis

The goal of Columbia Internal Medicine is to provide patient centered care to all of its patients. Patient centered care is a means for the provider, patient and families work together with the goal of providing quality healthcare to the patient. This will be achieved through patient and family interaction whereby the needs and preferences of the patient are communicated to Columbia Internal Medicine. Columbia Internal Medicine in turn will listen to these needs and then focus on their education and training to ensure better healthcare results.

Objectives

Columbia Internal Medicine and the patient will achieve this patient centered care based on the following mutually agreed upon terms:

Columbia Internal Medicine will provide quality healthcare to the best of their ability and knowledge, in a safe environment.

Patients and their families have the ability to ask questions and voice concerns through an open channel of communication with our providers.

The patient/parent is honest in the history of symptoms. Columbia Internal Medicine's provider is open and honest in relating the diagnosis and related treatment. It is important for the patient/parent to disclose all the symptoms or medical problems at the time of treatment.

The patient/parent is compliant in following agreed upon treatment plans. Columbia Internal Medicine will provide clear and understandable instructions.

Columbia Internal Medicine will provide patients with sufficient time during their office visit to ensure the medical problems are s understood and the treatment protocol is thoroughly explained. Both the patient/parent and provider shall respect one another's time.

The patient/parent will pay for their share of the provider services rendered not covered by their insurance at the time of the office visit. It is the patient/parent responsibility to know their insurance benefits.

Columbia Internal Medicine provides reasonable office hours and has instructions for after hour emergencies through their office telephone number, which includes access to a physician by phone 24/7.

Columbia Internal Medicine offers same day appointments for acute care and allots appropriate time frames for follow up, preventative care and disease management appointments.

• Columbia Internal Medicine may refer patients to a specialist or suggest certain tests/procedures that are not done in the office. Instructions will be provided for these instances. It is the patient/parent responsibility to find out if the specialist is covered by their insurance.

• Columbia Internal Medicine is not responsible for costs incurred by the patient for specialty care or tests/procedures recommended by our providers.

• Columbia Internal Medicine will facilitate the referral process. However, it is the responsibility of the patient/parent to follow up with the referral and understand the insurance coverage for the specific referral.

• Columbia Internal Medicine will provide results of lab/x-ray tests by calling the patient/parent. The patient/parent should call the office if not notified about test results in an appropriate time frame.

• The patient/parent shall do their best to participate in healthy habits and lifestyles.

• Columbia Internal Medicine may provide educational resources. The patient/parent utilizes these resources and asks questions if needed.

• The patient/parent will keep their appointments. Otherwise a missed appointment fee will be applied.

• The patient/parent shall arrive on time for their scheduled appointment. Columbia Internal Medicine in turn will work to stay on schedule.

• Columbia Internal Medicine will respect the patient/parent individuality. We will not make judgments based on race, religion, gender, gender identity, age or disability.

• Columbia Internal Medicine will respect patient/parent privacy. Medical information will not be shared with anyone unless it is vital for ongoing care, you give us permission, or it is required by law or court order.

• Columbia Internal Medicine participates in electronic prescription programs with affiliated pharmacies. Prescriptions are sent to your specified pharmacy electronically; otherwise, a printed prescription will be provided.

This agreement describing Columbia Internal Medicine optimal provider-patient relationship has been given to and has been received by a patient/parent by his or her provider today.

Patient (Signature) .....**Date**.....

Name (Print)..... .....

Provider..... **Date** .....

HIPPA Consent Form

I give consent to the above practice to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations, like quality reviews. I have been informed that I may review the practice's Notice of Privacy Practice (for a more complete description of uses and disclosers) before signing this consent. I understand that I have the right to request a restriction of how my processed health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

Signature: .....Date: .....

If signed by patient representative, state relationship to patient: .....

Authorization for Disclosure of Health Information

Date .....

I hereby authorize (name of the facility).....
to release the medical information from the records of -

Patient's Name ..... **DOB** .....

Street address/ State/ Zip code .....

Purpose or need for the disclosure Continued care Coordination of care

The information is to be released to:

Columbia Internal Medicine 2500 Pond View Ste # 202, Castleton NY 12033

Ph # 518-391-2889 Fax# 518-391-2304

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrolment in a health plan or eligibility of benefits. However information will not be released to the above recipient without my signature. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

I have the right to revoke this authorization by written notice to the Healthcare provider listed above. I understand that the actions taken in reliance of this authorization cannot be reversed and my revocation will not affect those actions.

I understand that my record may include information relating to drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (STD), AIDS related complex (ARC) and /or human immunodeficiency virus (HIV) and immunization record.

Fees: I understand that there may be costs associated with this request in compliance with the state laws.

This authorization will expire on (Date)..... or upon the event of .....

(if no date is specified, this authorization will expire in six months from the date of signature.)

Signature of the patient or authorized patient representative (*): .....

Date .....

(*) If signed by a patient representative, a description of the representative's authority to act is as follows:

Parent	Legal guardian	Healthcare proxy power of attorney	Administrator
Executor of estate	Next of kin	Beneficiary	

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Patient Treatment Waiver

Date:.....

(A)
I,..... (Name of patient) DOB.....
have a valid health insurance policy. I am seeking consultation/treatment from Dr. Padma Sripada.

If the health insurance company denies payment for my visits, I agree to pay the due charges in full, within the due date of the bill, including applicable collection charges explained below.

I specifically agree to reimburse the fees of any collection agency, which may be based on a percentage of maximum 33% of the debt and all costs, and expenses, including reasonable attorney fees, incurred by the practice, in such collection efforts.

Signature of patient.....

Witness by (Signature).....

Name (Print).....

(B)

Patients *Under the age of 18* & *Patients with Visitors' Insurance*

I agree to all the clauses under section (A) above.

Signature of Parent/ Guardian/ Local Guarantor.....

Name (Print) .....

Address.....

Phone # (Home).....Phone# (Cell) .....

Witness by (Signature).....

Name (Print).....

Hixny

Hixny Electronic Data Access Consent Form
Columbia Internal Medicine

In this Consent Form, you can choose whether to allow Columbia Internal Medicine to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Columbia Internal Medicine to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **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.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Columbia Internal Medicine's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Columbia Internal Medicine may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for Columbia Internal Medicine to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Columbia Internal Medicine to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____ _____ _____
Print Name of Patient Date of Birth Date

_____ _____
Signature of Patient or Patient's Legal Representative Print Name of Legal Representative (if applicable)

_____
Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Columbia Internal Medicine 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

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.

What Types of Information About You Are Included

If you give consent, Columbia Internal Medicine may access ALL of your electronic health information available through Hixny. 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*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

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 Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Columbia Internal Medicine's medical staff who are involved in your medical care; health care providers who are covering or on call for Columbia Internal Medicine's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 Columbia Internal Medicine at: (518) 391-2889; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Columbia Internal Medicine 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. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Columbia Internal Medicine. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny 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.

Copy of Form

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