MEDICAL REGISTRATION FORM

It will be helful to have your insurance card on hand when filling out this form.

Patient Identification:

Last Name: **First Name:**

Preferred Name: **Date of Birth:**

Social Security Number: ***(may provide in person if desired)***

How did you hear about Gianna of Syracuse?

Contact Information:

Address Line 1:

Address Line 2:

City/State:

Zip code:

Home Phone Number:

Mobile Number:

Work Phone Number:

Email:

Contact Preference: Home phone ◯ Cell phone ◯ Email ◯

Do we have your permission to CALL and remind you about appointments (check box if yes)? ☐

Do we have your permission to TEXT and remind you about appointments (check box if yes)? ☐

May we leave a voicemail (check box if yes)? ☐

Emergency Contact:

Name: **Phone Number:**

Relation to patient:

<u>Billing Information</u>:

Payment Preference:

Insurance Company Name:

Insurance Company Phone:

Insurance Company Address:

Policy Holder Name ***(if different from patient)*****:**

Policy Holder DOB ***(if different from patient)*****:**

Policy Holder SSN ***(if different from patient)*****:**

Policy Holder Address ***(if different from patient)*****:**

Policy Holder Relationship to patient:

Holder ID Number:

Group Number:

Insurance Plan Type:

Copay:

Healthcare Information:

Primary Care Physician:

Address: Phone:

Primary Ob-Gyn Physician:

Address: Phone:

Preferred Pharmacy:

Address: Phone:

Preferred Laboratory Site:

Address: Phone:

Preferred Imaging Facility:

Address: Phone:

Gianna Center Policy Regarding Reproductive Health Services

We are a Catholic medical center. We provide effective, scientifically-based, ethical alternatives for preventing and achieving pregnancy, treating infertility and managing reproductive health problems.

It is the policy of the Gianna Center to adhere to the Ethical and Religious Directives for Catholic Health Services which prohibit Catholic Health Centers from providing:

- Birth control
- Abortion
- In vitro fertilization, intrauterine insemination and other assisted reproductive technologies
- Infertility treatments in unmarried couples

These services are not available at the Gianna Center and all care offered at the Gianna Center is consistent with Catholic medical ethics.

At the time of your first visit, you will be asked to sign a waiver acknowledging your awareness of this policy.

By signing below, you acknowledge that you understand the above Policy of the Gianna Center and any questions you have asked have been answered to your satisfaction.

Patient Name: _____

Signature: _____ Date: _____

Gianna
OF CENTRAL & WESTERN NEW YORK

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

Signature of Facility Representative

Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations, Gianna of Syracuse may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit **Gianna of Syracuse** to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

(Relationship to patient)

(Relationship to patient)

I expressly permit **Gianna of Syracuse Medical** to disclose my protected health information for the purposes of appointment/test/procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

	Yes	No	Number:
Home voicemail:	◉	○	
Office voicemail:	◉	○	

Other (Please specify): _____

Signature of Patient/Personal Representative/ Parent/Guardian

Date

Patient Authorization, Assignment of Benefits & Financial Agreement

Patient name: **Date of Birth:** **Effective date:**

I acknowledge and understand that by signing below, I hereby authorize payment directly to Gianna of Syracuse Medical for services rendered to me, as specified more fully below.

Medicare:

- I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
- I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
- I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
- I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
- The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
- I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
- My authorization will remain in effect unless I revoke my authorization in writing.

Other Insurance Plan Participation: The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.

- I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
- I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
- I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

Non-Covered Services: I understand that each Plan *(i.e.,* HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.

- I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
- I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
- I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

Release of Information:

- I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
- I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

Financial Agreement:

- In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
- If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
- If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
- If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
- I agree to be primarily responsible for the payment of the Practice's bill.

Beneficiary Signature or Authorized Party: **Date:**

Informed Consent for Telehealth Services

PATIENT NAME: _____	DATE OF BIRTH:	MEDICAL RECORD #:
LOCATION OF PATIENT: _____	_____	_____

PHYSICIAN NAME: Angela M. Kristan, MD LOCATION: Home Office	DATE CONSENT DISCUSSED:
CONSULTANT NAME: _____ LOCATION: _____	_____
CONSULTANT NAME: _____ LOCATION: _____	

Telehealth, which includes telemedicine, involves the use of electronic information and communications to enable health care providers at different locations to deliver health care services to an individual when he/she is located at a different site than the provider. The services shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient.

I understand that telehealth services are being delivered, and hereby consent to **Angela Kristan, MD** providing care services to me via telehealth.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in or at a remote site while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the technology;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- The provider cannot guarantee that the encounter is confidential, as a person on the patient's end may be able to overhear conversations related to the patient's care;
- There are limitations to using telehealth for the patient's care as it does not involve a hands-on examination. For example, the encounter may result in a need for the patient to come to the office or another facility for further treatment: a patient-to-provider "hands-on" assessment, a procedure, a test, etc., and the patient must be willing to cooperate with that need should it be identified.

Please initial after reading this page: _____

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telehealth services can only be provided to patients, including myself, who are located in the state of New York at the time of this service.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telehealth

I have read and understand the information provided above regarding telehealth, I have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize Dr. Angela Kristan to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness: _____ *Date:* _____

I have been offered a copy of this consent form (patient's initials) _____

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.