Long Island Comprehensive Medical Care, PLLC

TODAYS DATE_____

PLEASE INFORM FRONT DESK IF THIS IS A WORKERS COMPENSATION OR NO FAULT VISIT

NAME: LAST MIDDLE FIRST				**DATE OF BIRTH**
ADDRESS: STREET TOWN STATE ZIP				
HOME PHONE:	**CELL PHONE:**	**WORK PHONE:**	**RACE:**	**ETHNICITY:**
SOCIAL SECURITY #	**Male___ Female_____**	**PRIMARY LANGUAGE:**	**OCCUPATION:**	**MARITAL STATUS: M___S____D___**
NAME OF EMPLOYER		**PHARMACY NAME ADDRESS TELEPHONE**		
EMPLOYMENT STATUS: Full Time___Part Time___Retired__ Unemployed Disabled			**EMAIL ADDRESS:**	
EMERGENCY CONTACT INFORMATION NAME: RELATIONSHIP: PHONE:				
PRIMARY INSURANCE:			**INSURANCE PHONE:**	
INSURANCE ADDRESS:			**POLICY HOLDERS NAME:**	
INSUREDS RELATIONSHIP TO PATIENT:	**INSUREDS DATE OF BIRTH:**	**MALE__FEMALE___**	**SOCIAL SECURITY # INSURED:**	
INSURANCE ID #:			**GROUP OR POLICY #:**	
INSURED'S EMPLOYER:		**INSUREDS EMPLOYERS ADDRESS AND TELEPHONE:**		
SECONDARY INSURANCE:			**INSURANCE PHONE:**	
INSURANCE ADDRESS:			**POLICY HOLDERS NAME:**	
INSUREDS RELATIONSHIP TO PATIENT:	**INSUREDS DATE OF BIRTH:**	**MALE__FEMALE___**	**SOCIAL SECURITY # INSURED:**	
INSURANCE ID #:			**GROUP OR POLICY #:**	
INSUREDS EMPLOYER:		**INSUREDS EMPLOYERS ADDRESS AND TELEPHONE:**		

I certify that the information I have reported about my insurance coverage is correct. If the insurance information provided is incorrect, invalid or one of the providers is not listed as my primary care physician, I understand that I will then assume responsibility for any unpaid balances

Date_____**Name (Print)**_____

Signature_____

LONG ISLAND COMPREHENSIVE MEDICAL CARE, PLLC

PLEASE SIGN AND DATE BOTH AUTHORIZATIONS/POLICIES

PATIENT AUTHORIZATION FORM FOR PAYMENT

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Long Island Comprehensive Medical Care to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Long Island Comprehensive Medical Care, PLLC (or to the party who accepts assignments.)

_____ _____ _____

Date *Signature* *Print Name*

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We make every effort to value your time and schedule your appointment time just for you. We truly appreciate your courtesy of giving us 24 hours' notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your health and keeping your scheduled appointments allows us to be partners in your care.

- By signing below, I acknowledge I am required to provide a 24-hour notice to make any changes to my appointment. If I fail to do so a $30 charge will be applied to my file.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment cancellation Policy of the practice and agree to be bound by its terms. I also understand that this notice may be changed at any time by the practice.

Signature_____Date_____

Printed Name_____

HIPAA Consent Form and Acknowledgement for Notice of Privacy Practices

Patient Name (Print):_____**Patient Date of Birth:**_____/_____/_____

Phone Number: ( )_____ **Email:**_____

As a result of the Health Insurance Portability and Accountability Act (HIPAA) enforced by the US Department of Health and Human service office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices or in accordance with your wishes below.

This consent authorizes Long Island Comprehensive Medical Care, PLLC to send/give my medical information as noted:

Leave a voicemail recording including my Personal Health Information on my home telephone_____Yes_____NO

Leave a voicemail recording including my Personal Health Information on my cell phone _____Yes_____NO

Leave a voicemail recording including my Personal Health Information on my business phone:_____Yes_____NO

Leave a voicemail regarding appointment changes, cancellations or confirmations on my home, Cell phone or business phone number: _____Yes_____NO

Use of electronic communication systems (i.e. fax, electronic message) to transmit prescription, Treatment, disorder related information, lab or other results: _____Yes_____NO

Permit the individual stated below (Personal Representative) to receive prescriptions and/or Test results: _____Yes_____NO

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information _____Yes_____NO

Name of Designated Personal Representative (Print):_____

Relationship to Patient (Print):_____

On this date_____**, I received and reviewed Long Island Comprehensive Medical Care, PLLC's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get this information. I understand that my medical information may be maintained in an electronic Health record and accessed remotely or transmitted securely over the Internet.**

I acknowledge that by giving this consent to this Organization, any, or all of the physicians within Long Island Comprehensive Medical Care, PLLC thatare involved in my care may access these records.

I had an opportunity to raise questions regarding this policy and all my questions have been answered _____Yes_____NO

The authorizations mad above will remain effective until such a time as I notify Long Island Comprehensive Medical Care in writing, by certified mail, of requested changes.

_____ _____

Patient or Personal Representative Signature **Today's Date**

_____ _____

Print Name **Relationship to patient if patient unable to sign**

Long Island Comprehensive Medical Care, PLLC

Your doctor would like you to please take a minute to complete this assessment. Please return the completed form to the front counter. Thank You!! Please circle your answers

Patient Name:_____ DOB: _____/_____/_____Date: _____

1) Do you have or does your family have a history of high blood pressure? Yes or No

2) Have you ever had a stroke or does your family have a history of stroke? Yes or No

3) Do you have or does your family have a history of diabetes? Yes or No

4) Do you ever have chest pain? Yes or No

5) Do you get palpitations/anxiety often? Yes or No

6) Do you get headaches often? Yes or No

7) Do you ever feel shortness of breath? Yes or No

8) Do you experience dizziness/lightheadedness often? Yes or No

09) Do you have or does your family have a history of glaucoma? Yes or No

10) Have you often experienced your leg cramping when walking? Yes or No

11) Do you experience pain in your legs, even at rest? Yes or No

12) Do you experience numbness/tingling in your legs? Yes or No

13) Do you experience numbness/tingling in your arms Yes or No

14) Have you tried to lose weight with no results? Yes or No

15) Do you have any skin sun spots, moles, skin tags, etc? Yes or No

16) Do you have trouble sleeping? Yes or No

17). Do you experience any of these symptoms more than twice a year: Cough, cold, congestion difficulty breathing headaches, wheezing, runny nose, sore throat, itch irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation or snoring? Yes or No

18). Have you ever been diagnosed with asthma or bronchitis? Yes or No

19) Do you experience symptoms of allergies? Yes or No

20) Regarding possible food allergies, do you experience any of the following? (check all that apply)

[ ] Bloating after eating [ ] Diarrhea [ ] Constipation [ ] Nausea
[ ] Upset Stomach [ ] Stomach pain [ ] Indigestion [ ] Vomiting
[ ] Tingling of the mouth or any other unusual sensation

Tobacco Screening

Patient Name_____

1. Do you currently smoke? Yes or No
2. Does anyone in your home smoke? Yes or No
3. Have you ever smoked? Yes or No (If answered No to question 1,2 & 3 do not continue questionnaire)
4. If yes how long ago did you quit?_____
5. At what age did you begin smoking?_____
6. Do your currently have COPD or Asthma?_____
7. If you answered yes to question 1 how much do you smoke a day_____.
8. Are you seriously thinking about quitting smoking completely? Yes or No if no skip to question 13
9. Are you planning to quit smoking completely within the next 30 days? Yes or No

10. How much would you say you want to **STOP** smoking? (*Please circle one.)*

1	**2**	**3**	**4**
not at all	not much	some	a lot

11. How much would you say you want to **KEEP** smoking? (*Please circle one*.)

1	**2**	**3**	**4**
not at all	not much	some	a lot

12. If you decided to quit smoking during the next month, how confident are you that you could do it?

1	**2**	**3**	**4**
not at all	not much	some	a lot

13. How much do you think that cigarette smoking can harm your health? *(Please circle one.)*

1	**2**	**3**	**4**
not at all	not much	some	a lot

14. How many of your family members and friends whom you see regularly are cigarette smokers?

1	**2**	**3**	**4**
None	not many	some	a lot

15. How many cigarette smokers, **NOT INCLUDING YOURSELF**, live in your home?_____smokers

16. How is cigarette smoking handled in your home? (*Please circle one.)*
1. No one is allowed to smoke **3.** People are allowed to smoke in my home only in certain areas
2. Only special guests are allowed to smoke in my home **4**. People are allowed to smoke in my home

17. If you tried to quit smoking, how much support or understanding do you think you would get from family, friends, and coworkers

1	**2**	**3**	**4**
not at all	not much	some	a lot

18. Have you done any of the following to help you try to quit or stay off cigarettes:

- Participated in a group quit-smoking program or clinic? Yes or No
- Participated in a one-to-one quit-smoking program with personal counseling or support? Yes or No
- Used a quit-smoking guide or video with personal counseling or support? Yes or No
- Used nicotine gum? Yes or No
- Used nicotine skin patches? Yes or No
- Tried hypnosis? Yes or No
- Tried acupuncture? Yes or No
- Tried other methods Yes or No

Dear Patients,

As part of our transition to Electronic Health Records we would like you to take a few minutes to complete the following information. If an email is provided to us, please check for a invitation to set up online access to our portal. You will be able to access your health information that will better assist us in providing the best possible care. Thank you for your cooperation with this.

Name_____

Date of Birth_____

Email_____

Race: American Indian ( )
Asian ( )
Black ( )
Native Hawaiian ( )
Unknown ( )
White ( )
Decline to answer ( )

Ethnicity: Hispanic ( )
Non Hispanic ( )
Unknown ( )
Decline to answer ( )

Primary Language: _____

Secondary Language:_____

PREFERRED COMMUNICATION; phone email mail **please circle**

Preferred Pharmacy Information

Pharmacy Name_____

Address_____

Phone Number_____

Long Island Comprehensive Medical Care, P.L.L.C.

1231 Deer Park Ave, North Babylon N.Y. 11703*** Tel 631-667-0388 Fax 631- 968-7705

New York State Health Insurance Law for Consumer Protection

What is this disclosure about?
This disclosure has been developed as a requirement of the New York State Health Insurance Law for consumers to protect patients from surprise medical bills including network adequacy requirements, claim submission requirements, access to out-of-network care and prohibition of excessive emergency charges." The requirements of the Surprise Bill Law go into effect March 31, 2015 (with limited exceptions).The aim of this disclosure is to inform you, the patient, of the non-emergency services we will bill your insurance provider for any medical service rendered to you at the time of care.

You can request a copy of this disclosure to take with you.

Days and hours of operation	Long Island Comprehensive Medical care is open: Monday- 9:00am - 7:00pm Tuesday- 8:00 AM- 6:00 PM Wednesday- 9:00AM - 6:00PM Thursday- 9:00 AM- 6:00 PM Friday- 9:00 AM – 6:00 PM Sat- 8:30am - 1:30pm Sun- 8am-5pm
Providers on Staff	Dr. Khalid Noori, Dr. Chetan Sati, Dr. Natacha Tessono, Dr. Gabrielle Henriksen, Tiffany Pascale, P.A., Nicolle Bergin, NP, Devin Bonura, PA, Hamza Jalal, DO, Rosa Casamassa NP, Jae Woo Chung, DPM, Omer Aci, DPM
Hospitals and Other Facility Affiliations	Good Samaritan Hospital Brookhaven Memorial Hospital Apex Rehabilitation and Care Millspond Rehabilitation Sayville Nursing Home East Neck Nursing Home Sunrise Assisted Living Brookside MultiCare Our Lady of Consolation
Health Insurance Participation	We accept all major health insurance plans with whom any of the above listed providers are selected as your pcp (primary care provider but due to the new plans added by the New York Health Exchange Program please call your health insurance plan to confirm we are in network of their plan.
Specialists,	As this is constantly changing, we are unable to guarantee that

Providers, Labs and other facilities you are referred to	the specialist, lab, or any other facility you are being referred to is in network with your health insurance plan. For a more timely confirmation please call the health facility first prior to making your appointment, to ensure the facility is in network with your health insurance plan.

By signing below, I affirm that I have read and understand the above disclosure on the New York State Health Insurance Law for Consumer Protection.

Print Name: _____, Date: _____

Signature: _____