NEW YORK CITY OSTEOPATHY, PLLC

40 Exchange Place, Suite 1704, New York, NY 10005

(Tel) 212-344-5361 / (Fax) 212-514-5460

Website: www.nycosteopathy.com / Email: nycovm@gmail.com

NEW PATIENT REGISTRATION

****Please be sure to indicate N/A if question does not apply.***

DATE: _____

Patient Name: _____, _____ _____
Last First MI

Preferred Name (If Any): _____

D.O.B: _____/_____/_____ **SS#**_____-_____-_____

Gender: ( ) Male ( ) Female ( ) Other: _____

Phone: _____ _____ _____
Cell Home Business

Patient Email: _____

Preferred method of communication/appointment reminders: ( ) Mobile Phone ( ) Home Phone

( ) Email ( ) Text

Preferred Language: ( ) English ( ) Spanish ( ) Other: _____

Home Address: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip:** _____

Business Address: _____

Business Address Line 2: _____

City: _____**NY:** _____ **Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Fax#:**_____

Preferred Pharmacy: _____ **Phone & Zip Code:** _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____

***Who referred you to us?** _____

May we use your name in our thank you/ acknowledgement for the referral? ( ) Yes ( ) No

INSURANCE INFORMATION

Primary Insurance: _____

Primary Insur. ID#: _____

Secondary Insurance: _____

Secondary Insur. ID#:_____

Primary Insured name & DOB: _____

Relation to Insured: _____

***(PLEASE PROVIDE COPY OF FRONT AND BACK OF INSURANCE CARD/S)**

Responsible Party Statement:

This practice does not accept No-Fault, Worker's Compensation, Medicaid, or private insurance. This has been fully explained to me, and I agree to be responsible for payment of all fees.

For Medicare Patients:

NYC Osteopathy, PLLC accepts assignment for Medicare patients and we submit electronically. Your signature below serves as a "Signature-on-File" and authorizes us to release medical information as necessary to process claims. It also authorizes payment of Medicare benefits and your secondary carrier directly to NYC Osteopathy, PLLC.

By signing below you consent to be fully responsible for the fees should your payment be denied by either carrier.

_____

Print Name **Signature** **Date**

OFFICE USE ONLY: Patient Acct. #_____ Entered By: _____ Date: _____

Patient Name: _____

Chief Complaint

Height: _____'_____ **Weight:** _____ **lbs.**

How may we help you today/what are your chief complaints?

_____
_____
_____
_____

How and when did it start?

_____
_____
_____
_____

How bothersome is this problem? Does it interfere with your daily activities? Does it keep you up at night?

_____
_____
_____
_____

On a scale of 1-10 (1 being mild and 10 being worst) how would you rate it? (*Please Circle*)

1 2 3 4 5 6 7 8 9 10

Is the pain like anything you've felt in the past? (Please Circle)

Knife-Like A pressure sensation Like a toothache Other (specify):_____

_____
_____
_____

Is the pain located in a specific area or has it changed over time?

_____
_____
_____

Does it radiate to a specific area of the body?

_____
_____
_____

What makes it better?

_____
_____
_____

Patient Name: _____

What makes it worse?

_____

_____

_____

What are any associated symptoms?

_____

_____

_____

Do you have any weakness or sensory changes?

_____

_____

_____

Medical History / Preventive Care

What specialists or therapies have you consulted/undergone for this condition?

_____

_____

_____

_____

What imaging studies have you had for this condition:

X-rays: ( ) Yes ( ) No

Body Part: _____

Date of Exam: _____

MRI: ( ) Yes ( ) No

Body Part: _____

Date of exam): _____

CT-Scan: ( ) Yes ( ) No

Body Part: _____

Date of Exam: _____

Other: ( ) Yes ( ) No

Type: _____

Body Part: _____

Date of Exam: _____

Current Medications

Name of Medication	Dose	Frequency

Patient Name: _____

Allergies

Drug Allergy

Name:_____ Severity (please circle): Very Mild Mild Moderate Severe

Name:_____ Severity (please circle): Very Mild Mild Moderate Severe

Name:_____ Severity (please circle): Very Mild Mild Moderate Severe

Environmental Allergy

Name:_____ Severity (please circle): Very Mild Mild Moderate Severe

Name:_____ Severity (please circle): Very Mild Mild Moderate Severe

Name:_____ Severity (please circle): Very Mild Mild Moderate Severe

Major Events

What Previous Medical Issues Have You Ever Had?

_____

_____

_____

_____

What Previous Surgeries Have You Ever Had? When?

_____

_____

_____

Have You Ever Been Hospitalized? (Please describe reason for hospitalization and when)

_____

_____

_____

_____

Ongoing Medical Problems

Are You Currently Being Treated For Any Medical Conditions? (Please describe)

_____

_____

_____

_____

Do You Currently Have Any Implantable Devices or Metals In The Body? ( ) Yes ( ) No

If Yes, please specify: _____

Patient Name: _____

Immunizations (If yes, check and indicate last date received)

_____ Influenza / Date: _____ _____ Shingles / Date: _____

_____ Tetanus / Date: _____ _____ MMR / Date: _____

_____ Pneumonia / Date: _____

_____ COVID / Date: _____ _____ Other Vaccination / Date: _____

Name of COVID vaccination: _____ Please specify: _____

Social History

Occupation/ Profession: _____

Hobbies:_____

_____

_____

_____

Tobacco Use: _____ / Frequency: _____

Alcohol Use: _____ / Frequency: _____

Cannabis Use: _____ / Frequency: _____

IV Drug Use: _____ / Frequency: _____

Nutrition History

Diet/Nutrition (Please describe):

_____

_____

_____

_____

Exercise Routine (Please describe):

_____

_____

_____

_____

***Please be sure to return completed paperwork before your scheduled appointment day for doctor's review and guarantee of your appointment placement.**

Family History *(Please Indicate the Family Member & Check or Specify Which Medical Condition Applies)*

Family Member: _____

Deceased: ( ) Yes ( ) No Age of Death: _____ Cause of Death: _____	Depression: ( ) Yes ( ) No	Seizures: ( ) Yes ( ) No
Alzheimer's: ( ) Yes ( ) No	Diabetes: ( ) Yes ( ) No	Stroke: ( ) Yes ( ) No
Alcoholism or Drug Use: ( ) Yes ( ) No	Heart Disease: ( ) Yes ( ) No	Suicide: ( ) Yes ( ) No
Asthma: ( ) Yes ( ) No	High Blood Pressure: ( ) Yes ( ) No	Thyroid Disease: ( ) Yes ( ) No
Autoimmune Disease: ( ) Yes ( ) No Please Specify: _____	High Cholesterol: ( ) Yes ( ) No	Tuberculosis: ( ) Yes ( ) No
Anxiety: ( ) Yes ( ) No	Osteoarthritis: ( ) Yes ( ) No	Other: ( ) Yes ( ) No If Yes, Specify: _____
Bleeding Disorder: ( ) Yes ( ) No	Osteoporosis: ( ) Yes ( ) No	
Cancer: ( ) Yes ( ) No If Yes, Type of Cancer: _____	Other Mental Illness: ( ) Yes ( ) No If Yes, Specify: _____	

Family Member: _____

Deceased: ( ) Yes ( ) No If Yes, Age of Death: _____ Cause of Death: _____	Depression: ( ) Yes ( ) No	Seizures: ( ) Yes ( ) No
Alzheimer's: ( ) Yes ( ) No	Diabetes: ( ) Yes ( ) No	Stroke: ( ) Yes ( ) No
Alcoholism or Drug Use: ( ) Yes ( ) No	Heart Disease: ( ) Yes ( ) No	Suicide: ( ) Yes ( ) No
Asthma: ( ) Yes ( ) No	High Blood Pressure: ( ) Yes ( ) No	Thyroid Disease: ( ) Yes ( ) No
Autoimmune Disease: ( ) Yes ( ) No Please Specify: _____	High Cholesterol: ( ) Yes ( ) No	Tuberculosis: ( ) Yes ( ) No
Anxiety: ( ) Yes ( ) No	Osteoarthritis: ( ) Yes ( ) No	Other: ( ) Yes ( ) No If Yes, Specify: _____
Bleeding Disorder: ( ) Yes ( ) No	Osteoporosis: ( ) Yes ( ) No	
Cancer: ( ) Yes ( ) No If Yes, Type of Cancer: _____	Other Mental Illness: ( ) Yes ( ) No If Yes, Specify: _____	

NYC OSTEOPATHY

40 EXCHANGE PLACE, STE 1704, NEW YORK, NY 10005

TEL 212-344-5361 / FAX 212-514-5460

COVID19 SCREENING QUESTIONAIRE

1- Are you or anyone in your household experiencing: (*please circle*)

Fever

Coughing or Sore Throat

Difficulty breathing or shortness of breath

Loss of taste or smell

Diarrhea

Nausea or vomiting

Headache

Fatigue

Chills or Shaking

Muscle aches and pains

Congestion or Runny Nose

2- Has anyone in your household tested POSITIVE for COVID? ____Y _____N

3- In the past 2 weeks have you been TREATED for COVID? _____ Y _____N

****If you responded YES, we are asking that our patients:***

Provide a Negative COVID test after 5 days symptom free or wait 10 days post symptoms to schedule your appointment.

Vaccination Status

Have you received a COVID 19 vaccine? ____Y ____N

Booster? _____ Y _____ N

Which vaccine did you receive? (please circle)

Pfizer

Moderna

Johnson Johnson

Another product: _____

Don't know

Date of Vaccination? _____/_____/ _____

How long ago did you receive your last vaccine (this includes the booster)? _____

Patient Signature: _____Date _____

NYC OSTEOPATHY, PLLC
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: September 23, 2013
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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. Revoke your authorization to use or disclose health information except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. Receive notification if affected by breach of unsecured PHI.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information 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.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (Inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at NYC Osteopathy, PLLC or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

NYC Osteopathy, PLLC
Privacy Officer
40 Exchange Place
Suite 1704
New York, NY 10005
Tel: (212) 344-5361
Fax: (212) 514-5460

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

NYC OSTEOPATHY, PLLC
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Patient ID #:** _____

I hereby acknowledge that I have received a copy of NYC Osteopathy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney
- ☐

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ **but acknowledgment could not be obtained because:**

- ☐ **Patient/representative refused to sign**
- ☐ **Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)**
- ☐ **Communication barriers prohibited obtaining acknowledgement (Explain)**

_____

_____

_____

_____

_____

- ☐ **Other (Specify)**

_____

_____

NEW YORK CITY OSTEOPATHY, PLLC

40 Exchange Place, Suite 1704, New York, NY 10005

(Tel) 212-344-5361 / (Fax) 212-514-5460

CANCELLATION POLICY

Our office has a policy of charging a fee for missing an appointment with less than one working days' notice. This policy will be explained verbally and by means of this notice.

We would like to explain the reason for this policy. This office takes seriously the time we have set aside for your visit. We try our best to adhere to the schedule and not keep you waiting. We do not "double book" appointments as some offices do to cover broken appointments and late cancellations. By not keeping your appointment or not notifying us in a timely fashion, patients who need "same day" urgent care or consecutive follow-up care are being obligated to wait longer than necessary.

If you call our office with less than 24 hours' notice, our front desk staff will make every effort to fill the appointment by notifying those patients who are on our cancellation list. If we are able to fill the appointment, we will not charge you any fee. If we cannot fill the appointment, your account will be charged the full office fee for the visit.

Acute health problems and family crises are beyond anyone's control and will be taken into consideration. Cancellations of convenience or last minute schedule conflicts will be your responsibility. We remain available to discuss this policy in general or by individual circumstance.

Thank you for your understanding.

Brian J. Waldron, D.O.

BJW:jw

Patient Name: _____

Signature: _____

Date: _____