GETWELL MED-CARE P.C.

SHAMIM AHMED, MD, FACP; *Board Certified Internal Medicine*
CHLOE *EUNSUNG CHOI, FNP; Board Certified Nurse Practitioner*
JOSLINSUNGATHI, PAUL FNP; Board Certified Nurse Practitioner
SUVA, BOSE PA; Board Physician Assistant
FERDOUS SALAUDDIN, MD, MRCP (UK); Board Certified Internal Medicine

PATIENT DEMOGRAPHIC FORM

I. Patient Information

*Patient Name (Last, First, M): _____

*Date Of Birth (mm/dd/yyyy): _____ Sex: □ Male □ Female

*Patient's Address: _____

* City: _____ *Zip Code: _____

*Patient's Contact Number: _____

*Home #_____ *Work # _____

*Email: _____

*Social Security: _____

*Primary Language: _____

*Employment: □Part Time □Full Time □Retired □Unemployed

*Student: □Part Time □Full Time

*Employer or School Name: _____Phone #: (____)_____

*Emergency Contact Name: _____Phone #: (____)_____

*Relationship to Patient: _____

*Marital Status: □Single □Married □Divorced □Widowed □Legally Separated

*Race: □Asian □American Indian or Alaska Native □ Black or African-American □ White □Unknown

*Ethnicity: □Not Hispanic □ Hispanic

*Pharmacy Name: _____ Phone #: (____)_____

II. Insurance Information

Primary Insurance Company: _____Insured ID:_____

Patients Relation to Insured (check one): □Self □Spouse □Child □Other _____

Secondary Insurance Company: _____Insured ID:_____

Patients Relation to Insured (check one): □Self □Spouse □Child □Other _____

Social Security: _____

IV. Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information to process this claim. I permit a copy of the authorization to be in the place of the original. I hereby authorize Dr. Shamim Ahmed to apply for benefits on my behalf for covered services rendered by his, or by his order. I request that payment from my insurance company be made directly to Dr. Shamim Ahmed. I permit a copy of authorization to use in place of the original. This authorization may be revoked by either me or my insurance company at any time.

V. Patient Consent for Use and Disclosure of Protected health Information.

I have read a copy of GETWELL MEDCARE notice of Privacy Practices. With my consent, GETWELL MEDCARE, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). With my consent, GETWELL MEDCARE may call my home or other designated locations and leave a message on voicemail or in person reference to any items that assist the practice in carrying out (TPO), such as appointment reminders, insurance items and call pertaining to my clinical care, including laboratory results among others. With my consent, GETWELL MEDCARE may mail to my home or other designated location any items that assist the practice to carrying out (TPO), such as appointment reminders cards and patient statements. By signing this form, I am consenting to GETWELL MEDCARE use and disclosure of PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, GETWELL MEDCARE may decline to provide treatment to me.

DATE: ____ /____ /____ **Signature:** _____

(Patient, Parent or Guardian)

PATIENT AUTHORIZATION to ACCESS MOUNT SINAI MEDICAL RECORDS via CARELINK

Patient's Name:

_____

(Last) (First) (Middle)

Date of Birth: _____ Tel. No.:___/____/_____

Month/Day/Year

Address: _____

(Street) (City) (State) (Zip Code)

I authorize my provider **GetWell Med-Care, PC / Dr. Shamim Ahmed** to access my Mount Sinai medical records through CareLink

I understand my HIV, Alcohol and Drug Use, Psychiatric/Mental Health and Genetic information may be included.

I understand that this authorization is valid as long as I am under the care of the above noted healthcare provider and may be revoked by me at any time except to the extent that action has been taken based on my authorization.

GetWell Med-Care, PC / Dr. Shamim Ahmed will not condition treatment or payment on whether you sign this authorization.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s)as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Print Name: _____

Authority: _____ Tel. No: _____

Address: _____ Date: _____

{Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf}

To request records or to revoke authorization, send a written request to:

GetWell Med-Care, PC
Site Contact: Maureen Yson
35-30 64th Street, Woodside, NY. 11377 and 170-25 Cedarcroft Road, Jamaica, NY. 11432
Fax: 718-205-4815

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Getwell Med-Care, PC.** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Getwell Med-Care, PC** to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for **Getwell Med-Care, PC** to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

GETWELL MED-CARE P.C.
35-30 64th St. Woodside, NY 11377
170-25 Cedarcroft Road, Jamaica, NY 11432
Tel: 718-205-6561/718-305-1262 Fax: 718-205-4815

Acknowledgement and Consent

HIPAA (Health Insurance Privacy Accountability Act)

Patient's Name: _____ DOB: ___/___/___

By signing below, I acknowledge that I have been provided a copy of Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Dr. Shamim Ahmed and his business associates 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, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care (referrals), disclosure to school, to seek and receive payment for services given to me, and for the business operations of Dr. Shamim Ahmed and his staff, and the facilities.

_____

Signature of patient or authorized representative

Relationship to Patient: _____ Date: ___/___/___

AFFIRMATION OF PRIOR RECEIPT

By signing below, I acknowledge that I have already received a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. I do not wish to receive another copy of the Notice of Privacy Practices at this time.

_____

Signature of patient or authorized representative

Relationship to Patient: _____ Date: ___/___/___

A professional corporation dedicated to humanity. We care for your good health.