Mount Sinai Doctors *Faculty Practice*

Icahn School of Medicine at Mount Sinai

PATIENT INFORMATION

Last name:	**First**:	**Middle Initial**:
Marital Status: ✔ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	**Birth Date**:	**Sex** ☐ M ☐ F
Street Address/PO Box:	**City**:	**State & Zip Code**:
Email address:		
Cell/Mobile phone:	**Home Phone**:	**Work Phone**:
Employer Name:	**Employer Address**:	**Occupation**:

REFFERAL SOURCE

)

INSURANCE INFORMATION

Person responsible for bill: ☐ Self	**Birth Date**:	**Address** (if different):	**Home Phone**:
Occupation:	**Employer**:	**Employer Address**:	**Employer Phone**:
Name of primary insurance:			
Subscriber's Name: ☐ Self	**Birth Date**:	**Group #**:	**Policy #**:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

SECONDARY INSURANCE (IF APPLICABLE)

Name of secondary insurance:	**Subscriber's Name**:	**Group #**:	**Policy #**:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

IN CASE OF EMERGENCY		
Please notify in case of emergency:	**Relationship to Patient**:	
☐ Check if address is the ***same*** as in patient information		
Address:	**City, State**:	**Zip**:
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize **Mount Sinai Doctors Faculty Practice** and/or insurance company to release any information required to process my claims**.**

Patient/Guardian signature:	**Date**:

Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

FPA Psychiatry Transparency Attestation Form
Privacy and Your Electronic Medical Record

Mount Sinai[i], including the Psychiatry Faculty Practice Associates, utilizes an Electronic Medical Record (EMR).

Your Electronic Medical Record contains all of the same information that would otherwise be included in your paper medical record, but will help us improve the quality of the care you receive at Mount Sinai.

We are always concerned about your privacy and have taken special precautions to ensure that the information you share during your visit remains confidential. In keeping with that, psychiatric visit notes are protected in the EMR and cannot be seen by other health care providers in the Mount Sinai Health System outside of the Department of Psychiatry. **Medications, tests ordered by your psychiatric health care provider and your problem list, which may include mental health diagnoses, are kept in a separate section of the EMR and are viewable to other healthcare providers outside of the Department of Psychiatry.**

If you would prefer that your mental health problem list remains not viewable by other health care providers outside of the Department of Psychiatry, please speak to your Psychiatric Health Care Provider.

Tests ordered, such as lab tests, and the results of those tests that are completed at MSHS, will be viewable by your other health care providers. . If you have concerns about this information being shared with other health care practitioners in the health care system, please speak to your provider about using an outside laboratory. **Due to the fact that New York State now has mandatory electronic prescribing, medications must be ordered through the EMR and your other healthcare providers will be able to view the medications that are electronically prescribed to you.**

While electronic prescribing is mandatory in the state of New York, we believe that including your medications in the EMR is the safest approach to your care. Not including medications could result in important information about your care not being readily available to providers taking care of you in an emergency situation and puts you at undue risk.

By signing this form you acknowledge the receipt of the above information regarding privacy and your Electronic Medical Record.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date:

Treatment Provider Name: Jacob Ham, PhD

Treatment Provider Signature: _____ Date:

[i] Mount Sinai comprises The Mount Sinai Hospital, Mount Sinai School of Medicine, Faculty Practice Associates, North Shore Medical Group, Mount Sinai Hospital of Queens, Mount Sinai Diagnostic and Treatment Center.

Mount Sinai Doctors *Faculty Practice*

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I, _____, hereby consent to have my Mount Sinai Doctors Faculty Practice physicians communicate with me or members of his/her staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his/her office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

E-mail: _____

Patient Signature: _____ Date: _____

Personal Representative Name: _____

Personal Representative Authority: _____

Responsible Party Signature: _____

Mount Sinai Doctors *Faculty Practice*

ACKNOWLEDGEMENT OF RECEIEPT OFNOTICE OF PRIVACY PRACTICES (NOPP)

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 hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

_____
Patient Name

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient to refuse to sign despite good faith effort*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other, (explain):* _____

Employee Signature:_____ Employee Title: _____

Print Name:_____ Date: _____

- ☐ Acknowledgement subsequently obtained, (see above).

Healthix

MOUNT SINAI HEALTH INFORMATION EXCHANGE (HIE) AND HEALTHIX CONSENT FORM

Mount Sinai Doctors *Faculty Practice*

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants is updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of "The Mount Sinai Health System" (defined in MS HIE Fact Sheet) to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where yov get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE. PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. I can also change my decision at any time by completing a new form. You have the following choices below. Please check Box 1 or 2:

☐ 1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of my electronic health information through the Mount Sinai HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ 2. IDENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access my electronic health information through the Mount Sinai HIE or and IDENY CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ANY of my electronic health information through HEALTHIX for any purpose, even in a *medical emergency.*

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by applicable law.

If Iwant 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.

Patient Name (Print) _____ Date of Birth _____

Signature of Patient/Patient's Legal Representative/Date _____

Print Name of Legal Representative (if applicable) _____

Mount Sinai Doctors *Faculty Practice*

Patient Name: _____

Date of Birth: _____

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients) ☑ Yes ☐ No (Please initial) ____

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. _____ (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION ● Yes ☐ No (Please initial) _____

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

☐ Yes ☐ No (Please initial) _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website or can be provided to me upon request.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though the Physicians may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting http://www.mountsinai.org/patient-care/find-a-doctor ; I also understand that I can also determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting the facility's web portal.

I understand that the Physicians charge for their services separately from the hospitals and facilities in the Mount Sinai Health System, and that any bills from hospitals or facilities in the Mount Sinai Health System for so-called "facilities" or "technical" fees will be sent separately from the Physicians bills for their "professional" services.

I understand that it is my responsibility to check with the "physician" arranging for my services regarding: (1) whether the services of any other physicians will be required for my care; and (2) whether the services of any other physicians (including but not limited to anesthesiologists, pathologists, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "physician" arranging for my services to obtain the contact information and/or health plan participation information for any physicians or facility whose services may be needed in connection with my care, and that I can also contact those physicians directly to obtain information regarding their health plan participation.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE

Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card**.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient Name:	**Patient Signature**:	**Date of Birth**:
Today's Date:		

Guarantor Name: (if not the patient)	**Guarantor relationship to patient:**	**Guarantor Signature**:

The Mount Sinai Hospital
One Gustave L. Levy Place Box 1230
New York City, N.Y. 10029-6574

Mount Sinai Credit Card Authorization

Type of Card to be Charged: ☐ VISA ☐ MasterCard ☐ American Express

Card number

CCV:

Expiration date:

Cardholder Name _____ Cardholder statement billing address _____

Patient Last Name _____ Patient First Name _____

☐ ☐ ☐

_____ _____

_____ _____

Authorization:

The Signer below agrees to pay the total amount specified above in accordance to the card issuer agreement (Merchant agreement if Credit voucher)

Cardholder Authorization_____ Date_____

Revised on 4/25/2014

Psychiatry Department Card Authorization

Type of Card: ☐ VISA ☐ MasterCard ☐ AMEX ☐ Discover ☐ Diners Club

Last 4 Digits of Card Expiration date:

Cardholder Name (Print name)

Patient Last Name Patient First Name

Authorization:

I _____, hereby authorize **Dr. Jacob Ham** And/or their designated employees to charge my credit or debit card on file for medical services provided during the service period indicated above.

Cardholder Signature _____ Date _____

Revised on 1/12/2016