Albany Medical Center Plastic Surgery

New Patient Information
(Confidential)

Demographics

Name: _____ Todays Date: _____

Date of Birth: _____ Age: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Pharmacy: _____ Pharmacy Address: _____

Emergency Contact Name & Phone Number: _____

Primary Care Physician: _____

Referring Physician: _____

Other Care Providers: _____

Health History

Reason for Today's Visit: _____

Height: _____ Weight: _____ Gender: M F

Do you have or have you had any of the following conditions: (please check all that apply)

☐ Anemia	☐ Migraines	☐ Skin Cancer	☐ Asthma
☐ Cancer	☐ Liver Disease	☐ Diabetes	☐ Bleeding Disorder
☐ Glaucoma	☐ Arthritis	☐ Thyroid Disorder	☐ Cataracts
☐ Stroke	☐ Bladder Disorder	☐ Fractures	☐ Hay Fever
☐ High Blood Pressure	☐ Leukemia	☐ Tuberculosis	☐ High Cholesterol
☐ Back Pain	☐ Bronchitis	☐ Stomach Ulcers	☐ Prostate Problem
☐ Kidney Disease	☐ Hepatitis	☐ Depression	☐ Colitis
☐ Seizures	☐ HIV / AIDS	☐ Infectious Disease	☐ Psychiatric
☐ Loss of Weight	☐ Scars	☐ Chemical Dependency	☐ Bleeding Disorders
☐ Irregular Heartbeat	☐ Sore that won't heal	☐ Hernia	☐ Heart Disease
☐ Change of Moles	☐ Breast Lump	☐ Arthritis	☐ Gout

Please list any **Medical Conditions** you are currently being treated for or have had in the past, including significant trauma or injuries requiring hospitalizations:

_____

_____

_____

Please list any **Surgeries** you have had (include dates of the operation):

_____

_____

_____

Date of last Tetanus Immunization: _____

PLEASE CONTINUE TO SECOND PAGE (back of form)

Albany Medical Center Plastic Surgery

New Patient Information

(Confidential)

Occupation: _____

Please circle *YES* or *NO* for the following questions:

Do you smoke: YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Do you drink caffeine? YES NO If yes, how much? _____

Do you have a history of drug or alcohol abuse? YES NO

Have you ever had a blood transfusion? YES NO

Please list the **Current Medications** you are taking, including vitamins and herbal medications:

_____

_____

_____

_____

_____

Please list any **Allergies:**

_____

_____

_____

Family History: List any medical conditions your blood relative have or had

Mother: _____ Father: _____

Sister: _____ Brother: _____

Grandmother: _____ Grandfather: _____

Female Patients Only:

Pregnancy: Number of pregnancies _____ Number of Children _____

Are you currently pregnant? YES NO

*Female **Breast** Patients Only:*

Do you regularly have a Mammogram? YES NO If yes, date of last exam _____

Current bra size _____ Date of last menstrual cycle _____

I certify that the above information is correct to the best of my knowledge. I will not hold my Physician or any member of his/her staff responsible for any errors of omission that I may have made in the completion of this form.

X _____ _____

Signature Date

_____ _____

Reviewed by Date

ALBANY MED FACULTY PHYSICIANS
MORE THAN 400 EXPERTS PRACTICING WHAT THEY TEACH.

Albany Medical College
Faculty Group Practice General Acknowledgement

47 New Scotland Avenue, Albany New York 12208-3478

PROVIDER: ALBANY MEDICAL COLLEGE*

**Albany Medical College includes multiple physician practices, such as Surgery, Medicine, Women's Health, Pediatrics and Neurosciences. This acknowledgment applies to all Albany Medical College physician practices.*

PATIENT: _____

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Albany Medical College for any services furnished to me by that provider. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature of Beneficiary/Patient Date

If the patient is physically or mentally unable to sign:

_____
Name of Patient

By: _____ _____
Signature of Individual Signing on Patient's Behalf Date

_____
Address of Individual Signing on Patient's Behalf

I am signing on behalf of the patient in my capacity as: (check one of the following boxes and complete the section below entitled "Reason patient unable to sign")

- ☐ Legal guardian or representative
- ☐ Representative payee (a person designated by the Social Security Administration or other governmental agency to receive an incompetent beneficiary's monthly cash benefits)
- ☐ Relative
- ☐ Friend
- ☐ Representatives of agency or institution usually responsible for providing patient's care
- ☐ Representative of governmental agency providing assistance to patient
- ☐ If none of the above are available, representative of AMC

Reason patient unable to sign:

NON MEDICARE

I hereby assign all medical and or surgical benefits to which I am entitled, including private insurance benefits, and any other health plan benefits to Albany Medical College.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understandhat my insurance benefits are subject to verification by Albany Medical College and that I will remain responsible for any unpaid charges whether or not covered by this assignment to the full extent permitted by law. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____
Name of Insurance Company Insurance ID#

Signature of Patient/Legal Guardian or Representative (POA) X _____

Relationship to Patient: _____ _____

I am in receipt of the following:

- ☒ Albany Medical Center Notice of Privacy Practices
- ☒ Albany Medical College Financial Policy

X _____ _____
Signature Date

ALBANY MED FACULTY PHYSICIANS

Albany Med Faculty Physicians
Permission to Disclose Protected Health Information for Facilitation and Coordination of Care

Albany Med Faculty Physicians providers may use their judgment in disclosing health-related information to individuals involved in the care of a patient when in the provider's judgment it is in the best interests of the patient and consistent with each person's involvement in the care of the patient. Patients also have the right to identify those individuals they want involved in their care and with whom health-related information may be shared. These persons may include family members, other relatives, close personal friends, guardians of adults and other people identified by the patient. Finally, a patient has the right to request personal information not be shared with certain individuals as explained in the Notice of Privacy Practices.

Please provide us with the names of those individuals who are involved with your care to which we may disclose (share) your protected health information to facilitate or coordinate your care.

In the event that you are a parent or legal guardian of a child treated by Albany Med Faculty Physicians, please provide us with the names of those individuals who are involved with the child's care to which we may disclose (share) the child's protected health information to facilitate or coordinate the child's care.

Name of individual	Relationship
Name of individual	Relationship
Name of individual	Relationship

This form does not give individuals listed above the power to make healthcare decisions on behalf of the patient. Individuals are only authorized to make healthcare decisions on behalf of an incapacitated patient in the event of a Healthcare Proxy, Guardianship or if they are a surrogate (spouse, family member, or friend) within the meaning of the Family Healthcare Decisions Making Act.

By signing below, it is my intention to agree to the disclosure of protected health information to these designated individuals currently involved in my care or that of my child in the same manner as if I were personally present at the time of all such disclosures. This permission is not intended to exclude any other persons who are or may become involved in my care or the care of my child. I understand that I have the right to revoke this permission at anytime by personally notifying you or by sending my written notice of termination to

AMC Plastic Surgery

Patient's name (PRINT): _____

Signature of patient/parent/legal guardian: X _____

Date: _____

ALBANY MED FACULTY PHYSICIANS

MORE THAN 400 EXPERTS PRACTICING WHAT THEY TEACH.

PERMISSION FOR RECORDING

Albany Medical College's Faculty Physicians respect the rights of patients to either participate or refuse to participate in the photography and other recordings of their persons.

I, _____, as the (patient/patient representative) do hereby authorize and consent to the taking of photographic video and/ or audio recordings of the patient to be used for the following purpose(s) (please initial next to those agreed to):

____ **Education**
____ **Insurance**
____ **Treatment Progress**
____ **Teaching**

In addition, I ____Permit_____Do Not Permit the use of the patient's name in association with these recordings (but not for insurance purposes).

I understand that I may revoke the above consent for recording and/or use of the patient's name at any time.

By affixing my signature below, I certify that I have read and understand the above authorization and consent.

X_____ _____

PATIENT'S SIGNATURE **DATE**

For use if the patient is under the age of 18 (or if patient lacks capacity to consent):

_____ _____

AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____

(Print Name)

_____

RELATIONSHIP TO THE PATIENT

Department: Risk Management Albany Medical Center
Contact: Vice President, Risk Management
Policy and Procedure
Reference: JCAHO Standard, RI 2.50
Effective: 04/01/14

Albany Medical Center

New Scotland Avenue, New York 12208

_____Waiver Form for treatment without a valid referral OR non-covered services.
(Valid for this date only)

Patient Name:_____ MR#_____

I will be seeing_____. I agree to accept responsibility for payment in full for all services rendered, in the event they are not covered by my third party payor (e.g. my private insurance company, health maintenance organization, Medicare carrier, or out-of state Medicaid program). If a referral is required, yet not supplied, I understand that I may contact my provider today and have the appropriate referral faxed to this office. If a referral is not produced, or these services are excluded services, I agree to be financially responsible for these charges.

Services:_____
_____
_____

Reason:_____
_____
_____

_____
Signature (Patient, Parent, or Guardian)

_____ _____
Witness Date

ALBANY MED FACULTY PHYSICIANS
MORE THAN 350 EXPERTS PRACTICING WHAT THEY TEACH.

ALBANY MEDICAL COLLEGE FACULTY GROUP PRACTICE
PATIENT FINANCIAL POLICY

The Albany Medical College Faculty Group Practice is continuously striving to improve services to its patients. One of our goals is to provide patients with clear information about our financial policies so that there is no confusion at the time of the patient visit. The following is a summary of our patient financial policy.

PAYMENT OF CO-PAYMENT IS REQUIRED AT THE TIME OF SERVICE

Payment of applicable co-payment is required at the time services are rendered. The Albany Medical College Faculty Group Practice accepts cash, personal check, VISA and MasterCard. Failure to pay your co-payment at the time of service may result in the rescheduling of your appointment. There is a $30 service charge for returned checks.

The Albany Medical Faculty College Group Practice realizes that patients may have financial difficulty. Therefore, we may advise that due to your financial situation you set up payment arrangement with our billing office.

INSURANCE:

We are obligated to bill participating insurance companies; however, we bill non-participating insurance companies as a courtesy to you. In either case, you are expected to pay your co-payment at the time of service.

If you need assistance or have questions, please contact the Billing Coordinator between 8:00 a.m. and 4:30 p.m., Monday through Friday at 1-888-775-5277

REFUNDS:

Overpayments will be refunded to responsible parties. Should you have a question or concern regarding overpayments/refunds, please call 1-888-775-5277

ALBANY MEDICAL COLLEGE FACULTY GROUP PRACTICE
PATIENT FINANCIAL POLICY

REFERRALS:

If you are enrolled in a managed care plan, a referral from your primary care physician to a specialist must be received by our office in order for your services to be covered under your insurance. Retroactive referrals are not allowed. Failure of our office to receive the necessary referral prior to or at the time of service may result in the rescheduling of your appointment. It is recommended that you verify that a referral has been received by our office at least 2 days prior to your appointment.

MISSED APPOINMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 48 hours prior to the appointment. We reserve the right, unless legally prohibited, to charge $50 for missed or late-canceled appointments. Excessive missed or late-cancellations of scheduled appointment may result in discharge from the practice.

ALBANY MEDICAL CENTER
KNOWN FOR OUR EXPERTISE. CHOSEN FOR OUR CARE.

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM
Albany Medical Center

In this Consent Form, you can choose whether to allow Albany Medical Center to obtain access to your medical records through a computer network operated by the Healthcare Information X-Change of New York (HIXNY), doing business as HIXNY, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Albany Medical Center to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Albany Medical Center's staff involved in my care may see and get access to all of my medical records through HIXNY."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Albany Medical Center may not be given access to my medical records through HIXNY for any purpose."
HIXNY is a not-for-profit organization. It shares 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 HIXNY and eHealth in New York State, read the brochure, "Your Health Information – Always at Your Doctor's Fingertips." You can ask Albany Medical Center for it, or go to the website www.hixny.org.

Please carefully read the information on the back of this form before making your decision.

You're Consent Choices. You can fill out this form now or in the future. You have two choices.

CHECK ONE

o I **GIVE CONSENT for Albany Medical Center to access ALL of** my electronic health information through HIXNY in, connection with providing me any health care services, including emergency care.

o **I DENY CONSENT for Albany Medical Center to access** my electronic health information through HIXNY for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HIXNY.

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

Directions to our Office Locations

Malta North (MTMS) 6 Medical Park Drive Suite 203 Malta, NY 12020

From the North: Take I-87 S to Exit 12, follow signs for Ballston Spa/Route 67W at the first roundabout. At the second roundabout take the first exit onto Medical Park Drive.

From the South: Take I-87N towards Saratoga Spring/Glens Falls. Take Exit 12 and stay in the left lane, following signs for Ballston Spa/Route 67W. Turn slight right onto Dunning St/RT 67E. At the second roundabout, continue to follow signs for Route 67W. At the third roundabout, take the first exit onto Medical Park Drive.

*Please use the main entrance of the building - the double sliding glass doors by the carport. Go up to the second floor. The office is the second suite on the left-hand side.

Surgeon's Pavillion (PLSU) 50 New Scotland Ave, 1st Floor, Albany, NY 12208

From the North: Take I-87 S towards Albany. Take NY-2 exit, EXIT 6, toward Watervliet. Merge onto Troy Schenectady Rd. Enter the next roundabout and take the 1st exit onto Loudon Rd. Stay straight to go onto US-9 S/Louden Rd; continue to follow. Turn left onto Clinton Ave/US-9 S. Take the 1st right onto Lark St/US-9W S/NY-443. Turn right onto Madison Ave/US-20 W. Take the 2nd left onto New Scotland Ave. The Surgeon's Pavilion located at 50 New Scotland Ave will be located on your left. Turn left onto Veteran's Way and keep right to enter the 40 New Scotland Parking Garage.

*You may park in any space other than the restricted areas. Garage levels Ground, 2, and 5 all connect with floors on the 50 New Scotland Ave building; please note that garage level 2 connects with 2M of the 50 New Scotland Ave building. All garage levels are numbered and color coded. Our office is located on the 1st floor of the 50 New Scotland Ave building.

From the South: Take I-87 N towards Albany. Take US-9W exit, EXIT 23. Keep left to take the ramp toward Albany. Turn left onto US-9W/Southern Blvd. Continue to follow US-9W N. Turn slight right onto Southern Blvd/US-9W N. Turn right onto Delaware Ave/US-9W N/NY-443. Turn left onto Holland Ave. Turn sharp right onto New Scotland Ave. The Surgeon's Pavilion located at 50 New Scotland Ave will be located on your right. Turn right onto Veteran's Way and keep right to enter the 40 New Scotland Parking Garage.

*You may park in any space other than the restricted areas. Garage levels Ground, 2, and 5 all connect with floors on the 50 New Scotland Ave building; please note that garage level 2 connects with 2M of the 50 New Scotland Ave building. All garage levels are numbered and color coded. Our office is located on the 1st floor of the 50 New Scotland Ave building.