Westside Medical Associate, LLP 228 West 82nd Street, New York, NY 10024

Ira Breite, M.D. & Stephanie Rein, M.D.

Registration Slip (*Please Print Clearly!!)*

Patient Name_____ Social Security Number_____

Home Address_____Apt#_____ Date of Birth_____ Sex: M_____ F_____

City_____ State_____ Zip Code_____

Employer_____ ___Single ___Married ___Domestic Partner

Email_____ ___Divorced ___Widowed

Home Number ( )_____Cell Phone ( ) _____Business Number ( )_____

Insurance Information

Primary Insurance

Insurance Name_____

Policy #_____ Group_____

Insured (if other than patient)_____

Relationship to Patient_____DOB_____

Secondary Insurance

Insurance Name_____

Policy #_____ Group_____

Insured (if other than patient) _____

Relationship to Patient_____DOB_____

Emergency Information

Name of Emergency Contact_____

Phone Number of Emergency Contact_____ Relationship_____

Name of physician, friend, or relative who referred you to our office_____

Westside Medical Associates LLP
228 West 82nd Street
New York, NY 10024
(212)362-6468
(212)362-0851

Patient Privacy Statement

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carryout treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** This notice was published, and becomes effective on/or before **April 14, 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patients's Signature _____ Date_____

Payment Understanding

Payment Understanding

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any profession services rendered. I have read all the information and have completed all the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Patients's Signature _____ Date_____

Consent to Release Information

CONSENT TO RELEASE INFORMATION FOR TREATMENT

I consent to the use or disclosure of my protected health information (PHI) by Westside Medical Associates LLP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the practice. I understand that diagnosis or treatment of me by the practice may be conditioned upon my consent as evidenced by my acceptance on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment healthcare operations of the practice. The practice is not required to agree to the restrictions that I may request. However, if the practice agrees to a restriction that I request the restriction is binding on the practice. I have right to revoke this consent, in writing, at any time, except to the extent that the practice this taken action in reliance of this consent. My “Protected Health Information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse.

This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to review the practice's Notice of Privacy Policies (the Notice) prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the practice. The Notice is available from the reception area and is posted in the waiting room. The Notice also describes my rights and the practice's Notice of Privacy Policies (the Notice) prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the practice. The Notice is available from the reception area and is posted in the waiting room. The Notice also describes my rights and the practice's duties with respect to my PHI. The practice reserves the right to changer the privacy practices that are described in the Notice without prior notification. I may obtain a revised copy by calling the office and requesting a copy be mailed to me or picked up at the time of my next appointment.

Patients's Signature _____ Date _____

Westside Medical Associates
228 West 82nd Street
New York, NY 10024
P: 212-362-6468
F: 212-362-0851

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, without a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
Printed Name Date

_____
Signature

Westside Medical Associates - Intake and Progress Sheet

NAME:_____

DATE:_____

1) Were you referred by a friend or another doctor? If, yes, please let us know.

2) Why are you coming in today?

3) Do you have any allergies to MEDICATIONS (such as sulfa, penicillin).

4) Do you take any medications: Please give name, dose and frequency in chart below?

NAME	DOSE	TIMES A DAY

5) Please list any surgeries you have had and the years they took place.

6) Please list any medical problems, such as diabetes, hypertension, and asthma.

7) Is there a family history of cancer, heart disease or diabetes? Any other family history of note?