

DOUGLAS H. BAILYN, MD PC

111 Broadway, Suite 1302
New York, NY 10006
212-571-3331

380 Second Ave, Suite 1002
New York, NY 10010
212-777-1510

PATIENT INFORMATION QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ Apt Number: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Social Security #: _____ Email: _____

Patient's Employer: _____

Occupation: _____

Referred by (name and number of doctor): _____

Preferred Pharmacy and location/phone number: _____

*Prescriptions can be sent electronically to a *specific* pharmacy for your convenience.
(Ex: CVS on Broadway and Fulton or phone number. Not CVS or Duane Reade).

Emergency Contact: _____

Relationship: _____

Phone number: _____

Sex: Male Female

Marital Status: Married Single Divorced Widowed

*Required for survey through NYC Government:

Race: Asian Black/African American American Indian/Alaskan Native

Native Hawaiiin/Pacific Islander White Other

Ethnicity: Hispanic Non-Hispanic

Preferred Language: _____

Authorization Information Assignment of Benefits

I hereby assign to DR. DOUGLAS H. BAILYN any insurance or other third party benefits available for health care services that have been provided to me. I also understand that if benefits are assigned, or if by contractual arraignment, payment to the practice will be made by my insurance, that I am responsible for any co payments and deductibles and that these amounts are due at the time services are rendered. I also understand that if the insurance does not cover any of these services I will be responsible for all charges for services rendered. I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to remake payment, in full, for the services rendered to me (depending upon the assignment) at the time.

Signature: _____ Date: _____

PHYSICIANS PRIVACY POLICY
HIPAA
RELEASE OF INFORMATION and PRIVACY DISCLOSURE

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.

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule (“HIPAA”) governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Use and Disclosure of Protected Information To Others. Federal law provides that we may use your medical information (protected health information) for your treatment, without further specific notice to you, or written authorization by you. An example of this permitted use would be if we refer you to a specialist, we might provide laboratory or test data to that specialist (subject to more stringent New York laws, if any, such as New York’s restriction on Federal law disclosure of information concerning HIV/AIDS). Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. Examples of this are: 1) our accountants may see your name, dates of treatment and procedure codes during audits of our books, or 2) We may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may also use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law for public health purposes; 2. Required by law to report child abuse; 3. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct; 4. Required by law in judicial or administrative proceedings; 5. Required for law enforcement purposes by a law enforcement official; 6. Required by a coroner or medical examiner; 7. Permitted by law to a funeral director; 8. Required by law for organ donation purposes; 9. Permitted by law to avert a serious threat to health or safety; or 10. Permitted by law and required by military authorities if you are a member of the armed forces of the United States.

In addition, Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under your health plan we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Information Provided to You You have the right to choose how we provide medical information to you. For instance, you may ask us to send you medical information at a certain place, such as at your work address, or in a certain manner, such as by e-mail or by fax. We will do so if we reasonably and legally can, however, by requesting to have your medical information sent or transmitted to a non-private place (such workplace) or through a non-secure medium (such as e-mail or fax) you have released us from any liability that may arise from any resulting inadvertent disclosure of your medical information.

No Waiver of Rights. You will not be asked to waive your rights, including your right to file a complaint, as a condition of treatment.

Use or disclosure of your medical information will be made only with this written authorization, as needed to complete insurance billing or to give medical information for specialist referral purposes. You have the right to revoke this written authorization at any time, except to the extent we have already relied upon the authorization or in the event of an emergency.

I have read and understood this form, and all my questions about it have been answered.

Patient Signature: _____ Date: _____

Print Name: _____

EXISTING POLICIES

We would like to take this opportunity to make you aware of our existing policies.

1. Referrals

Managed care companies require that patients come in to the office to get a referral (even electronic referrals). Please be advised that the office has 72 hours from the initial request to provide patients with referrals. Be sure to allow enough time between your appointment with a specialist and Dr. Bailyn to ensure that all necessary referrals are complete. In case of emergencies or unusual circumstances, Dr. Bailyn reserves the right to overlook this policy.

2. Prescription Renewals

Prescription medicines can be a great help for medical problems that can be treated with medication. However, any medicine is potentially harmful if taken for the wrong reasons or in the wrong dosage. Therefore, Dr. Bailyn will not prescribe any medicine over the phone, except in extremely unusual circumstances and at his discretion. In general, Dr. Bailyn's rules are as follows:

-No renewals if you have not been seen in the last 3 months

-UNDER NO CIRCUMSTANCES WILL CONTROLLED SUBSTANCES OR PSYCHOACTIVE DRUGS BE RENEWED WITHOUT AN OFFICE VISIT.

I am aware of the existing policies and procedures.

Patient Signature: _____ Date: _____

Print Name: _____

MEDICAL INFORMATION
AND
TEST RESULTS RELEASE FORM

Choosing How You Want Your Medical Information Released As a result of the federal law entitled the Health Insurance Portability and Accountability Act (HIPAA), all physicians and medical offices are now required to obtain written permission to be able to transmit any health information by phone, fax or e-mail. You have signed a release authorizing Douglas H. Bailyn, MD, PC to release your protected health information to specific people or entities, including other physicians or health care providers, hospitals and testing services. This form tells us how we may release your protected health information to those people or entities and to yourself. If you ask Douglas H. Bailyn, MD, PC to send or transmit your protected health information through a non-secure medium (such as e-mail or fax), we cannot guarantee that it will remain private. By signing this form, you release Douglas H. Bailyn, MD, PC from any liability that may arise from any resulting inadvertent disclosure of your protected health information as a result of any non-public or non-secure methods of transmittal that you authorize.

All abnormal lab results will be reported to the patient by Dr. Bailyn within one week. Normal results will be mailed to the address we have on file. Therefore, please make sure you update your address with us as needed. Please note: we are human. Therefore, if you have not heard from us within one week, do not hesitate to call us.

I hereby authorized Douglas H. Bailyn, MD, PC to transmit my protected health information to authorized persons or entities by any means that Douglas H. Bailyn, MD, PC believes to be the most appropriate and in my best interest as a patient, including but not limited to fax, telephone, email, or other electronic transmission. I realize that I can change my mind at any time and revoke this authorization by writing to Douglas H. Bailyn, MD, PC. I understand that I have released Douglas H. Bailyn, MD, PC from any liability that may arise from any resulting inadvertent disclosure of my medical information as a result of any non-public or non-secure methods of transmittal that I have selected.

Please indicate below the way you would like us to send you your results, give us the corresponding information to send you your results and put your initials next to your choice.

FAX NUMBER FOR RESULTS: _____ Initials: _____

E-MAIL ADDRESS FOR RESULTS: _____ Initials: _____

I WILL PICK UP THE RESULTS: _____ Initials: _____

Patient Signature: _____ Date: _____

Print name: _____

RELEASE OF INFORMATION

I authorize the release of any medical information or other information as is necessary to process this claim based upon the HIPAA Notice of Privacy Practices, information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature: _____

Date: _____