

Insurance Verification and Referring Physician

-Please Print-

Date of Birth	Age	Gender at Birth	Gender Identity	Marital Status	Mobile Number
First Name	Middle Initial	Last Name			SSN or Last 4
Home Phone Number	E-Mail Address			Allow E-Mail Communications?	
				Yes ____ No ____	
Home Address	Apt #	City	State	County	ZIP Code
Work Phone & Extension	Employer Name		Employer's Address		

Please provide the referring Doctor(s) information as well as your Primary Care Practitioner if applicable:

Dr. Name: _____ Dr. Name: _____
 Address: _____ Address: _____
 Telephone: _____ Telephone: _____
 Fax(required): _____ Fax(required): _____

Would you like today's report forwarded to the above Doctor(s)? ____ Yes ____ No

Name of Escort: _____ Phone Number: _____

Did you bring a Health Care Proxy or Living Will to put on file? ____ Yes ____ No

1. Primary Insurance Name		Primary Insurance Address or Po Box	
Policy Number / Member ID		Group Number	
Policy Holder Name	Date of Birth	Relationship	Social Security #
2. Secondary Insurance Name		Secondary Insurance Address or Po Box	
Policy Number / Member ID		Group	
Policy Holder Name	Date of Birth	Relationship	Social Security #

Signature	Today's Date

Coronavirus Patient Screening Tool

Previous COVID-19 (SARS-CoV-2-RNA) Test: ☐ Yes ☐ No **Results:** ☐ Positive ☐ Negative
Test date: _____ (month/day/year)

1. Are you experiencing any symptoms of respiratory illness, fever, chills, cough, difficulty breathing, shortness of breath, sore throat or GI symptom of diarrhea or new loss of taste or smell, headache or myalgia (muscle pain or muscle ache)?
☐ Yes (Circle symptoms reported) ☐ No

2. If yes, approximately how long ago did you first notice symptoms? _____ Hours
_____ Days _____ Weeks

3. **Temperature at visit** _____ °F

In the past 14 days, have you traveled internationally? ☐ Yes ☐ No

4. If yes, where to? _____

Note: any positive response or temperature ≥ 100.4 °F, is considered a positive screening.

Inform patient if a mask is provided, it does not prevent spreading of the Coronavirus but is effective against the spread of the flu.

(Print) Patient Name

Signature

Date

Staff Only: If patient screens positive, notify the attending physician for direction.

Screener Signature: _____ **Date:** _____

Inform patient if a mask is provided, it does not prevent spreading of the Coronavirus but is effective against the spread of the flu
Note: any positive response or temperature > 100.4 F is considered a positive screening.

Staff Only:

Case Cancelled: ☐ Yes

Mask provided: ☐ Yes ☐ No **Notified Public Health Department:** ☐ Yes ☐ No

Patient Referred to: ☐ Primary Care Physician ☐ Emergency Room ☐ Public Health Department
☐ Urgent Care ☐ Other: _____



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 Kips Bay Endoscopy Center LLC 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 Kips Bay Endoscopy Center LLC to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Kips Bay Endoscopy Center LLC 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)



Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
 - **Treatment Services.** Provide you with medical treatment and related services.
 - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
 - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
 - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Sexually transmitted diseases	• Discharge summary
• Birth control and abortion (family planning)	• Medication and Dosages	• Employment Information
• Genetic (inherited) diseases or tests	• Diagnostic Information	• Living Situation
• HIV/AIDS	• Allergies	• Social Supports
• Mental health conditions	• Substance use history summaries	• Claims Encounter Data
	• Clinical notes	• Lab Test
3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.
5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Kips Bay Endoscopy Center LLC at 212-889-5477; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.
English | Provider Consent | Non-Emergency