ROCKLAND PULMONARY & MEDICAL ASSOCIATES

a member of Bon Secours Medical Group

Clement Osei, M.D.
Leon S. Harris, M.D.
Stephen M. Menitove, M.D.
Jack W. Horng, M.D.
Bauer, Kristy, M.D.
Berg, Jonathan, M.D.
Benjamin G. Chang, M.D.
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Mary P. Leahy, M.D.
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Kathleen Begley, A.N.P.c.
Catherine Burke, N.P.c.
Patricia Underwood, A.N.P.
Michele Muldoon, A.N.P.c.

Dear New Patient,

For your convenience we have enclosed the following forms to be completed by you before your scheduled appointment. If returning by mail please allow at least five business days before your appointment.

Attached are forms for you to complete. **Registration form (complete the front only), Patient Medication Record and Special Authorization Forms.** The **Special Authorization Form** is used to share information in your medical chart with other physicians and family members.

Our last form that we have enclosed is the **Notice of Health Information Privacy Practices** for your review. Review the information and sign the written acknowledgment stating that Rockland Pulmonary & Medical Associates, P.C., has given you the Notice of Health Information Privacy Practices to review.

On the day of your appointment, please make sure that you bring your insurance card and referral, if needed. You will also need to bring your actual chest x-ray films if you have a pulmonary consult scheduled.

Please arrive 15 minutes early so that we can prepare your medical chart.

If you have any questions you can contact our Medical Records/Health Information Management department at 845-353-5600, press option #3.

10/2011

2 Crosfield Avenue, Suite 318 West Nyack, NY 10994
257 Lafayette Avenue, Suite 340 Suffern, NY 10901
Tel: (845) 353.5600 • Fax: (845) 353.5668

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MUST BE FILLED OUT COMPLETELY * PLEASE PRINT CLEARLY

Patient Registration

MR#

DATE:

PATIENT INFORMATION

NAME: FIRST: | MI: | LAST:

ADDRESS:

CITY, STATE & ZIP:

PHONE: | DATE OF BIRTH: | SS#:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER | SEX: ☐ MALE ☐ FEMALE

EMPLOYER NAME:

ADDRESS:

WORK PHONE: | CELL PHONE:

REFERRING PHYSICIAN: | PRIMARY CARE PHYSICIAN:

IN CASE OF EMERGENCY CONTACT: | RELATIONSHIP TO PT:

PHONE: | PHARMACY NAME:

ALLERGIC TO: | PHARMACY PHONE:

PRIMARY INSURANCE

INSURANCE NAME: | PHONE:

DOES YOUR INSURANCE REQUIRE A REFERRAL? ☐ YES ☐ NO

ADDRESS:

POLICY #: | GROUP #:

EFFECTIVE DATE: | CO-PAY AMOUNT:

NAME OF INSURED: | RELATIONSHIP TO PATIENT:

INSURED'S EMPLOYER: | INSURED'S DATE OF BIRTH:

SECONDARY INSURANCE

INSURANCE NAME: | PHONE:

DOES YOUR INSURANCE REQUIRE A REFERRAL? ☐ YES ☐ NO

ADDRESS:

POLICY #: | GROUP #:

EFFECTIVE DATE: | COPAY AMOUNT:

NAME OF INSURED: | RELATIONSHIP TO PATIENT:

INSURED'S EMPLOYER: | INSURED'S DATE OF BIRTH:

If you belong to an HMO/PPO that Rockland Pulmonary & Medical Associates, P.C. participates, your responsibility is restricted to the applicable co-pay. Co-payment is expected on date of service.

I consent to examination and treatment by the physicians and nursing staff of Rockland Pulmonary & Medical Associates, P.C.
I authorize Rockland Pulmonary & Medical Associates, P.C. to release any and all of my medical and/or dental records including but not limited to records of office visits and treatment rendered, clinical laboratory reports, diagnostics test results, x-rays reports, video tapes and photographs. Such records may be released to my attorney, another physician or any other health care professional for the purposes of discussing my condition, consulting on my case or reviewing medical records. These records may also be released to any governmental agencies insurance companies and employees or insurance companies for the purposes of pursuing payment, insurance reimbursement, submitting claims for services rendered to me or performing quality assurance reviews as required by law.

Patient Signature: | **Date:**

MEDICARE PATIENTS READ AND SIGN BELOW

I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration of their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself of the party who accepts assigmnent.

Patient Signature: | **Date:**

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Please complete this form and mail or bring in with your completed Health History.

If you have any questions, call Health Information at 845-353-5600 Option #3

Account # ______________________________

Date: __________________

Patient Name (please print): ______________________________________ Date of Birth: _____________

Allergies to medication:

MEDICATION LIST

☐ ***No medication taken***

Pharmacy Name: ______________________________ Phone: __________________

MEDICATION	STRENGTH	HOW OFTEN

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AUTHORIZATION TO RELEASE MEDICAL RECORDS TO OTHER PHYSICIANS, HOSPITALS, AND FAMILY MEMBERS

TO: Rockland Pulmonary and Medical Associates
2 Crosfield Avenue, Suite 318
West Nyack, NY 10994

FROM: (Print)
Patient's Name ______________________________
Address
____
____
Date of Birth ______________ Home Phone ______________
Work Phone ______________ Cell Phone ______________

RELATIONSHIP TO PATIENT:
Self ___ Spouse ___ Parent ___ Other (Specify) ______________

I hereby authorize you to make available to:
(Print Physician's or Other Person's Name, Address and Phone Number)
____
____
____
____

Copies of the records and/or reports checked below relating to my / the above named Patient's medical treatment:
___ Biopsy report(s) dated ______________
___ Lab report(s) dated ______________
___ Records and reports from ______________
to______________
___ All records and reports
___ Other (Specify) ______________

NOTICE TO PATIENT: Written request is required to release records to other designated Physicians or Hospitals as stated in Public Health Law, section 17. Only reports and lab results that RPMA has ordered for patient can be released.

SIGNED: ______________________ DATED: ____________
WITNESS: ______________________________

I do not wish to complete this form: ______________________ ________
Signature Date

4/11

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Welcome To Our Practice

We hope that the following information will be helpful in making Your visits and anything you may need easy to obtain.

We have 2 locations:

2 Crosfield Avenue, Suite 318
West Nyack, NY 10994

257 Lafayette Avenue, Suite 340
Suffern, NY 10901

Our Telephone number is 845-353-5600, phones are on:

Monday – Thursday	8:00 AM- 5:00 PM
Friday	8:00 AM- 4:00 PM

Closed for lunch between 12:00 noon- 1:00 PM

Our office Hours are

Monday – Thursday	8:00 AM- 6:00 PM
Friday	8:00 AM- 4:00 PM

Please always call for an appointment when needed, as we DO NOT take walk-in patients.

Our doctors are on call 24 hours a day for urgent problems after hours. When you make your appointment we will do our best to give you the doctor you request. In some cases you may have to see another Doctor or Nurse Practioners.

10/2011

REFERRAL INSTRUCTIONS

Referral Request

Use these steps to request a referral

1. Dial (845) 353-5800. Option #1 (Monday – Friday 9am – 4pm only)
2. When prompted, give all the information regarding your referral.
3. Wait 3 days to pick up referral in office. More time will be needed if mailed.
4. If request is for future referrals (more than 1 month in advance), they will be mailed 2 weeks prior to date of appointment.

Emergency Referrals

Please note: An emergency referral consists of a **TRUE MEDICAL** emergency.
Dial (845) 353-5600, press * and ask for the Referral Dept.

PLEASE REMEMBER

- Forgetting your referral is **NOT** an emergency and therefore it will be handled like a regular referral.
- You **MAY NOT** walk in and wait for a non-emergency referral.
- Appointments should not be made until your referral is in your hands, unless ordered by your doctor.
- If you show up at an appointment without a referral, **YOU MAY BE RESPONSIBLE FOR PAYMENT AT TIME OF APPOINTMENT**.
- **We require you to be seen in our office at least once a year in order to obtain referrals**.
- We **DO NOT BACKDATE** any referrals. It is the patient's responsibility to request the referrals with enough time for us to process.

We will not stop you from seeing any doctor that you feel you need to see, providing your medical records are current. However, due to Managed Care and our obligation to provide you with needed referrals, as well as the amount of requests we receive from our patients each day, we ask you to understand our waiting period of 3 to 4 days

In order to serve you better, please follow these guidelines for requesting referrals.

Thank you,

4/11

MEDICATION REFILLS

Our office has a prescription line that should be used when you need to refill your **medications**. Please call 845-353-5800, press option 2 and listen to the prompts. Please speak clearly and spell your first and last names. **You must allow 3 business days for your prescriptions to be processed**. If your insurance company requires prior authorization on a medication it may take up to one week to complete this process.

The prescription line is open 24 hours a day, 7 days a week; however, **medication refills are only done during office hours.**

If you have not been seen in our office in over 1 year and need medication, a one-time refill may be called in for you. However no further refills will be given until you are seen in our office.

Prescriptions can be electronically sent to your local or mail away pharmacy. However control substances (narcotics, sleep aids, etc) cannot be done without a doctor's approval and signature and must be picked up at the office or we can mail to your home.

To expedite your medication renewals, please do not leave your requests on any other line besides the prescription line; this will only delay the process.

If you need immediate or urgent assistance with a prescription, you can call our maim number 845-353-5600 press * and ask for the prescription department.

Thank you in advance for your cooperation with our office procedures.

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WRITTEN ACKNOWLEDGMENT

I acknowledge that I have received Rockland Pulmonary and Medical Associates, a member of Bon Secours Medical group **Notice of Privacy Practices**, which provides a description of the information uses and disclosures of my health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

____________________________ ____________________________
Print Patient's Name Signature of Patient / Legal Guardian

____
Witness

____
Date

ROCKLAND PULMONARY & MEDICAL ASSOCIATES
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Notice of Health Information Privacy Practices

It is the policy of Rockland Pulmonary and Medical Associates, P.C., (RPMA) that all personnel must preserve the integrity and the confidentiality of medical and other sensitive information pertaining to our patients. The purpose of this policy is to ensure that RPMA and its officers, employees, and agents have the necessary medical and other information to provide the highest quality medical care possible while protecting the confidentiality of that information to the highest degree possible so that patients do not fear to provide information to RPMA and its officers, employees, and agents for purposes of treatment. RPMA is required by law to maintain the privacy of your personal medical information and to provide you with this notice its privacy policies. PLEASE READ THIS CAREFULLY.

Treatment: RPMA MAY USE YOUR INFORMATION TO PROVIDE OR COORDINATE YOUR CARE. We may disclose all or any portion of your medical information to any of our physicians, other consulting or referring physicians, nurse practitioners, physician assistants, and other employees who have a legitimate need for such information to provide or coordinate your care.

Payment: We may release your information to determine coverage by an insurer for our services, billing, and claims processing. The information may be released to an insurance company, third party or other organization involved in the payment of your bill. This information may include copies or excerpts of your medical information that is necessary to receive payment.

Routine Operations: We may use and disclose your information during routine operations of the practice. An example of routine operations would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorneys or consultants working for the practice. These entities are called "Business Associates". We require our Business Associates to treat your information in the same manner that we do.

Research: Under certain circumstances, we may use and disclose your information within approved clinical research studies. Most clinical research studies require specific patient consent; however there may be some cases where a review of your information without patient contact may be conducted by the researchers.

Regulatory Agencies: We may disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

Law Enforcement/Litigation: We may disclose your information for valid law enforcement purposes as required by law or in response to a court order or subpoenas.

Public Health: We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

Worker's Compensation: We may release your information to Worker's Compensation agencies in the event your illness or injury may be related to your work.

Military/Veterans: If you are a member of the Armed Forces or a veteran, we may release your information as required by military command authorities.

As Otherwise Required: We may disclose your information in any situation in which such disclosure is required by law (for example, child or domestic abuse).