BE WELL PRIMARY HEALTH CARE CENTER, LLC

DIAGNOSTIC & TREATMENT CENTER
NYS ARTICLE 28 FACILITY

☐ 3007 Farragut Road, Brooklyn, NY 11210 T: (718)253-9355

☐ 1577 Fulton Street, Brooklyn, NY 11213 T: (347)915-1411

PEDIATRIC PATIENT REGISTRATION PACKET

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle:** _____

SS #: _____ **DOB:** _____ **Age:** _____ **Sex Assigned at Birth:** ☐ F ☐ M

Address: _____

City: _____ **Patient Phone*:** _____ ***If patient 17y or older***

State: _____ **Zip Code:** _____ **Patient Email*:** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language: ☐ English ☐ Haitian Creole ☐ Spanish ☐ Russian ☐ Other: _____ *(please specify)*

PARENT/LEGAL GUARDIAN #1

Name: _____ **Phone #:** _____

Relation to Patient: ☐ Mother ☐ Father ☐ Other: _____ **Email:** _____

PARENT/LEGAL GUARDIAN #2

Name: _____ **Phone #:** _____

Relation to Patient: ☐ Mother ☐ Father ☐ Other: _____ **Email:** _____

If Divorced/Separated, who is custodial parent/guardian? ☐ Parent/Guardian 1 ☐ Parent/Guardian 2

LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS*

EMERGENCY CONTACT

SOMEONE OTHER THAN PARENTS/LEGAL GUARDIANS WHO CAN BE CALLED IN CASE OF AN EMERGENCY

Name: _____ **Relation to patient:** _____ **Phone #:** _____

NO ACCESS

*IF THERE IS A PERSON WHO MAY **NOT HAVE ACCESS** TO THE CHILD'S INFORMATION/MEDICAL RECORDS, PLEASE INDICATE:*

Name: _____ **Relation to patient:** _____

Name: _____ **Relation to patient:** _____

LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY COURT ORDERS/ORDERS OF PROTECTION*

SIBLINGS

		Patient of Be Well?
Name: _____	**DOB:** _____	☐ Yes ☐ No
Name: _____	**DOB:** _____	☐ Yes ☐ No
Name: _____	**DOB:** _____	☐ Yes ☐ No
Name: _____	**DOB:** _____	☐ Yes ☐ No

COMPLETE 2ND PAGE →

PEDIATRIC PATIENT REGISTRATION PACKET (PAGE 2)

PRIMARY INSURANCE

Primary Insurance: _____ **Policy/ID#:** _____

Policy Holder Name: _____ **DOB**: _____

SECONDARY INSURANCE

Secondary Insurance: _____ **Policy/ID#:** _____

Policy Holder Name: _____ **DOB:** _____

*By signing below, I authorize the release of all medical information necessary to process this claim that is pertinent to my/the patient's medical care. I assign all medical and/or surgical benefits, including major medical benefits, to which I/the patient am entitled, to **Be Well Primary Health Care Center, LLC**, the provider of the services. These assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.*

Patient Name: _____
PLEASE PRINT

Signature*: _____
**IF PATIENT IS UNDER 18, SIGNATURE OF PATIENT PARENT OR LEGAL GUARDIAN*

Relation to patient*: _____ **Date:** _____
**IF SIGNED BY PERSON OTHER THAN PATIENT*

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PEDIATRIC PATIENT REGISTRATION PACKET (PAGE 3)

AUTHORIZATION FOR TREATMENT

1. By signing below, I give my consent to Be Well Primary Health Care Center, LLC (hereafter referred to as "Be Well"), the physicians, and other personnel on its medical staff, to administer such care, procedures, diagnostic tests, and treatment that is deemed necessary and in my/the patient's best interest. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment.
2. I authorize Be Well to utilize photographing, videotaping, or other forms of observation as may be appropriate for monitoring my/the patient's condition and the advancement of the medical knowledge and/or education with the understanding that my/the patient's identity will remain anonymous.
3. I understand that health care services received by me/the patient through Be Well may be covered by one or more health insurance policies or other health plans. I authorize Be Well to bill the insurance company directly, and to receive payment directly from the insurance company. I accept responsibility for all unpaid services, co-payments, co-insurance, and/or deductible amounts.
4. I understand that in providing or arranging these health care services, Be Well will learn personal medical information about me/the patient. I agree that Be Well may share my/the patient's medical information with any provider to whom Be Well refers me/the patient. I also agree that Be Well may obtain copies of medical records generated by the provider to whom I/the patient was referred for the purpose of ensuring continuity of care.
5. I agree that Be Well may share all of my/the patient's medical information with the insurance company, health plan(s), or other third-party payers, including any information concerning diagnosis or treatment of sexually transmitted diseases, HIV related conditions*****, mental disorders, or alcohol or drug abuse. However, my/the patient's agreement is limited to the extent that the sharing of medical information is reasonably necessary for the payment of the claim and the administration of health plan(s), including all procedures for quality and cost-efficiency.
6. I understand and agree that this consent shall apply throughout the period of time that I am/the patient is a patient of Be Well.

Also requires completion of "Authorization for Release of Confidential HIV Related Information" Form DOH2557

Patient Name: _____ **Date:** _____

Signature*: _____ **Relation to Patient*:** _____
**IF PATIENT IS UNDER 18, SIGNATURE OF PARENT OR LEGAL GUARDIAN*
**IF SIGNED BY PERSON OTHER THAN PATIENT*

Witness Signature: _____ **Date:** _____

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PEDIATRIC PATIENT REGISTRATION PACKET (PAGE 4)

RECEIPT OF NOTICES

By signing below, I confirm that I have received a copy of the following documents:

- **Patient Bill of Rights**

Patient Name: _____ **Date:** _____

Signature*: _____ **Relation to Patient*:** _____

**IF PATIENT IS UNDER 18, SIGNATURE OF PATIENT PARENT OR LEGAL GUARDIAN*

**IF SIGNED BY PERSON OTHER THAN PATIENT*

Witness Signature: _____ **Date:** _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**