3055 SOUTHWESTERN BLVD.
ORCHARD PARK, NY 14227
(716) 675 – 2500

3500 SHERIDAN DR.
AMHERST, NY 14226
(716) 204 – 4263

PATIENT INFORMATION (Please Print)

Today's Date: ___/ ___/ ___

Name ______________________________ Date of Birth ____/ ____/ ____
First M.I. Last

Address ______________________________
City State Zip

Home Phone ________________ Cell Phone ________________ Work Phone ________________

E-mail Address ______________________________

Social Security # ________________ Marital Status ________________ Sex ☐ M ☐ F

Race ________________ Language of Choice ________________ Ethnicity ________________

Primary Care Physician ______________________________
Name Address

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance ________________
ID Number ________________
Name of Primary Insured ________________
Date of Birth ________________
Social Security # ________________
Relationship to Patient ________________

Secondary Insurance ________________
ID Number ________________
Name of Secondary Insured ________________
Date of Birth ________________
Social Security # ________________
Relationship to Patient ________________

Pharmacy ________________ Address ________________

I authorize release of any medical information to my primary care and/or referring physician and those necessary to process insurance claims, insurance applications, and/or prescriptions. I also request payment of government benefits either to myself or to the party who accepts assignment below. I also authorize payment of medical benefits be made to the above- named physician for all services rendered to me. I understand that even though I have insurance coverage, I am responsible for payment of services, deductibles and/or co-payments.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ______________________________

Please be advised we do not accept workers compensation or no fault claims.

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PATIENT INFORMATION (Please Print)

Today's Date: __/ __/ __

Name ____ Date of Birth __/ __/ __
First M.I. Last

Primary Care Physician ____

Referring Physician if other than above ____

DO YOU HAVE A HISTORY OF OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? Please circle all that apply.

General:	weakness	frequent infections				
Head:	headache	sinus pain and congestion				
Eyes:	cataracts	contacts or glasses	blurred vision	double vision	glaucoma	
Ears:	hearing loss	ringing	infections	earache		
Mouth:	bleeding gums	sore tongue				
Neck:	swollen glands	tender glands	enlarged thyroid			
Respiratory:	wheezing	cough	pneumonia			
Cardiac:	chest pain	palpitations	ankle swelling	murmur	rheumatic fever	
GI:	nausea	vomiting	diarrhea	constipation	heartburn	
	stomach ulcer	blood in your stool	loss of appetite	abdominal pain	gallbladder disease	
Urinary:	pain	frequency	blood in your urine	nightly urination	kidney stones	
Genital:	sexually transmitted disease	vaginal/penile discharge	prostatitis	sexual dysfunction		
Endo:	diabetes	thyroid disease	temperature intolerance	excessive thirst		
Heme:	anemia	bleeding disorder	transfusions	blood clots		
Skin:	hives	itching	leg ulcers	acne	psoriasis	
Neuro:	fainting	numbness	tingling	seizures	tremors	stroke
Psych:	depression	anxiety	panic attacks			

Other ____

PLEASE NOTE DATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Flu vaccine _________________ Pneumonia shot ________________ Tetanus shot __________________

Hepatitis shots ________________ Shingles shot _______________ Skin test for TB __________________

Mammogram _______________ Pap smear ________________ Last menstrual period __________________

Age at Menopause _________________ PSA level ________________

PLEASE LIST YOUR MEDICATIONS AND HOW OFTEN YOU TAKE THEM: (or attach an additional sheet listing all your medications)

____

____

____

____

PLEASE LIST ANY ALLEGERIES YOU HAVE:

____

____

____

____

PLEASE LIST YOUR MEDICAL PROBLEMS:

____

____

____

____

PLEASE LIST SURGICAL HISTORY:

____

____

____

____

SOCIAL HISTORY:

Occupation ______________________ Currently you are: working / retired / disabled / sick leave

Who lives in your household? ____

List your Pets ____

Do you smoke? _______________ How much? ____________________ How long? ____________

Recreational drugs? ___________________ Alcohol? ______________ How often? ______________

Do you exercise? ________________________________ How often? __________________________

Dr. Joseph M. Grisanti
Dr. Michael W. Grisanti

Dr. Linda M. Burns
Dr. Harbrinder Sandhu

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACE NOTICE

I, ____ , understand that Buffalo Rheumatology may share my health information for treatment, billing, and healthcare operations. I have been offered a copy of the *Notice of Privacy Practices* that describes how my health information may be used and shared. My signature below constitutes my acknowledgement that I have reviewed the copy of the *Notice of Privacy Practices.*

PATIENT PRIVACY INFORMATION

Please list ANY family members or other persons, if any, whom we may inform about your general medical condition and/or your diagnosis.

______________________________ ______________________________
Name Phone Number

______________________________ ______________________________
Name Phone Number

Can confidential messages be left on your home answering machine, your cell phone or with another person? ☐ Yes ☐ No

Can we call you at work? ☐ Yes ☐ No

Can we send via mail? ☐ Yes ☐ No

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Legal Representative Relationship to Patient

Patient's Date of Birth ____

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Patient Consent to Participate in HEALTHeLINK Health Information Exchange
Level 1 Multi-Provider/Multi-Payer Consent

HEALTHeLINK

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

SELECT ONLY ONE

YES ☐ **I GIVE CONSENT for all Participants who are involved in my care to access ALL of** my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."

YES EXCEPT ☐ **I GIVE CONSENT for all Participants who are involved in my care to access ALL** of my electronic health information through HEALTHeLINK except the following Participants:

Participant's Name **Participant's address or phone number**

____

These Participants cannot access my electronic health information via HEALTHeLINK *EXCEPT in a medical emergency*. If you have chosen to exclude any Participants, you **must** contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here ☐

NO EXCEPT ☐ **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, EXCEPT *in a medical emergency*. By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."

NO NEVER ☐ **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, INCLUDING *in a medical emergency*.

NOTE: Unless you select "NO NEVER" New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE

Patient Last Name:

Patient First Name:

__ / __ / ____ ☐ **Male** ☐ **Female**

Patient Date of Birth:

Patient Address

City **State** **ZIP**

____
Signature of Patient or Patient's Legal Representative **Date of Signature**

____
Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ parent ☐ healthcare agent/proxy ☐ guardian ☐ other ____________

____
Entity Consent Received By

WITNESS *

* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.

____
Print Name of Witness

____
Signature of Witness

____
Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

HEALTHeLINK is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask a Participant for it, or go to the website www.ehealth4ny.org

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information Will be Used.**
   Your electronic health information will be used by the Participating Providers you approve **only** to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

   Your electronic health information will be used by the Participating **Payers** you approve **only** for:
   - **Quality Improvement Activities.** These include evaluating and improving the quality of medical care provided to you and all of the health insurer's members.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of health care 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.
   - **Pre-Authorization Activities.** These include reviewing and evaluating medical information in order to pre-approve services requested by you or your health care provider.

   NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK. You can obtain an updated list at any time by checking the HEALTHeLINK website at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved Participating Provider who are involved in your medical care; health care providers who are covering or on call for an approved Participating Provider's doctors; and staff members of an approved Participants who carry out activities permitted by this Consent Form as described above in item one. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

5. **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 one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at www.wnyhealthelink.com; or call HEALTHeLINK at 716-206-0993 ext. 311; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by the Participants to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HEALTHeLINK and persons who access this information through the HEALTHeLINK must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or HEALTHeLINK ceases to conduct business.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Participants. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on HEALTHeLINK's website at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

   Note: Organizations that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it.

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Buffalo Rheumatology and Medicine PLLC Financial Policy

Thank you for choosing Buffalo Rheumatology and Medicine PLLC as your healthcare provider. The billing department will work with you to fulfill your payment responsibility.

Buffalo Rheumatology and Medicine PPLC requires payment at the time of service. All applicable co-pays will be collected at the time of check-in for your appointment. You are responsible for any deductibles or co-insurances in accordance with your health insurance policy as well. Our office will collect a portion of this amount at the time of appointment check-in.

Self-Pay patients who require treatment without insurance will be required to pay $50 – $200 depending upon services rendered. This payment is to be made promptly after the patient has seen the provider before future appointments are made to ensure continuation of care by Buffalo Rheumatology and Medicine PLLC.

Deductibles and Co-insurances
Patients with deductible or co-insurance plans will be required to pre-pay a portion out of pocket before services are rendered. Procedures and drug administration quotes will be given prior to the patient's appointment. Pre-collection amounts are estimates only, as we are unable to determine services reimbursement due to the amount of different insurance plans. You will be billed for any remaining amount due after payment is received from insurance and pre-payment is applied, or refunded should you overpay.

Non-participating/Non-contractual Insurance Plans
Should Buffalo Rheumatology and Medicine PLLC not participate with your healthcare plan, you will be required to pay out of pocket for services rendered ranging from $50 – $200. This amount will be collected promptly after services are rendered, before scheduling future appointments to ensure continuation of care by Buffalo Rheumatology and Medicine PLLC.

Any questions or concerns regarding any of this policy please feel free to contact our billing department at 716-675-2500. Payment plans are available for those who qualify.

Signature ____ **Date** ___________________