BUFFALO RHEUMATOLOGY AND MEDICINE, PLLC

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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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:

____

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____

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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Authorization for Access to Patient Information Through HEALTHeLINK

Patient First Name

Patient Last Name

Date of Birth	**Patient Address**	**Gender**
MM / DD / YYYY	Street, Apartment City, State, Postal Code	☐ Male ☐ Female

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 Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at www.wnyhealthelink.com.

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.

SELECT ONLY ONE

My Consent Choice. Only 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.

Choice	Description
☐ **1. YES**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **4. NO, EXCEPT IN AN EMERGENCY**	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐ **5. NO, EVEN IN AN EMERGENCY**	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative

X________________________

Date of Signature

MM / DD / YYYY

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

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other________

This Box To Be Filled Out Only By The Provider

Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

Print Name of Witness

Signature of Witness

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

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **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 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

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

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 at www.wnyhealthelink.com or by calling 716- 206-0993 ext. 311.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com/PhysiciansandStaff/CurrentParticipants/ParticipatingHEALTHeLINKProviders or by calling 716-206-0993 ext. 311 if you want a hard copy which will be provided at no charge within 5 business days of the request.

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 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/.

6. **Re-disclosure of Information.** Any Participant(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.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first).*** If HEALTHeLINK merges with another Qualified Entity our consent choices will remain effective with the newly merged entity.

8. **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(s). Participant(s) 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 change your consent decision they are not required to return your information or remove it from their records.

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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** ___________________