# Harmony Health of WNY
## NEW PATIENT FORM

DATE ___________________ ACCOUNT # ________________

### PATIENT INFORMATION

Last Name ______________________________________ Date of Birth _____________________ Age _____________
First Name ______________________________________ Social Security # ________________________________
Address ________________________________________ Driver's License # ______________________________
City ___________________ State ______ Zip __________ Emergency Contact ______________________________
Home Telephone _________________________________ Telephone ________________________________________
Cell Phone ______________________________________ Address _________________________________________
Employer _______________________________________ _________________________________ Apt. # ________
Email __________________________________________ City ___________________ State ______ Zip __________
Who referred you to us? __________________________

Race: ☐ American Indian ☐ Asian ☐ African-American ☐ Alaska Native
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Sex: ☐ Male ☐ Female ☐ Transgender

### POLICY HOLDER INFORMATION (if patient is not policy holder relationship to policy holder ____________ )

Last Name ______________________________________ Social Security # ________________________________
First Name ______________________________________ Employer ________________________________________
Address ________________________________________ Cell Phone # _____________________________________
City ___________________ State ______ Zip __________ Message Phone # _________________________________
Home Telephone _________________________________ Date of Birth ____________________________________
Spouse's Name ___________________________________ Driver's License # ______________________________

### INSURANCE INFORMATION

Please enter information about the **POLICY HOLDER (if patient is not policy holder)**

Insurance Company ______________________________ Ins. Phone # _____________________________________
Group Number __________________________________ Employer ________________________________________
Insurance ID # __________________________________ Relationship to Patient ____________________________
Owner of the Policy ______________________________
Insurance Company Address _______________________ Is this a work related injury or motor vehicle injury? _________
________________________________________________

**Managed Care Programs:** If I am or become a member of an affiliated managed care program, I understand that it is my responsibility to know the limits and benefits of my plan. If I accept health services that are found by my plan to be "non-covered", I agree to promptly pay the customary charges for these services.

**I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to me to Harmony Health of WNY. A copy of this is as valid as the original. I understand that payment is due at the time of service, and I am totally responsible for my charges.**

Signature ______________________________________________________________ Date __________________________

(over)

## Consent to Treat

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the physicians of **Harmony Health of WNY**, their staff and designees, as may in their professional judgement, be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

____ Initial

## PHI Consent

I consent to the use or disclosure of my protected health information by **Harmony Health of WNY** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Harmony Health of WNY**

____ Initial

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Harmony Health of WNY** is not required to agree to the restrictions that I may request. However, if **Harmony Health of WNY** agrees to a restriction that I request, the restriction is binding on **Harmony Health of WNY** and the **physicians of Harmony Health of WNY**

____ Initial

I have the right to revoke this consent, in writing, at any time, except to the extent that the **physicians of Harmony Health of WNY** or **Harmony Health of WNY** has taken action in reliance on this consent.

____ Initial

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review **Harmony Health of WNY** Notice of Privacy Practices prior to signing this document. The **Harmony Health of WNY's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Harmony Health of WNY.** The Notice of Privacy Practices for **Harmony Health of WNY** is also provided in the reception room of the Practice. This Notice of Privacy Practices also describes my rights and the **Harmony Health of WNY's** duties with respect to my protected health information.

____ Initial

____ **I have been given the Harmony Health of WNY** Practice Notice of Privacy Practices for review.

Initial

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|---|---|
| ______________________________ | ______________________________ |
| **Signature of Patient of Personal Representative** | **Date** |
| ______________________________ | ______________________________ |
| **Name of Patient or Personal Representative** | **Description of Personal Representative's Authority** |

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Please list people with whom we can discuss your care and leave messages.

1)____________________________ Relationship to Pt ____________ Ph #________________________

2)____________________________ Relationship to Pt ____________ Ph #________________________

May we leave a message regarding your care on your answering machine? ( ) Yes ( ) No
May we leave a message regarding your care on your cell phone? ( ) Yes ( ) No
May we text you a message on your cell phone regarding your care? ( ) Yes ( ) No
(please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow-up of lab appointments, etc.)