SULLIVAN STREET

MEDICAL

NEW PATIENT INFORMATION

LAST_____ FIRST_____ MI_____

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER_____

STREET_____ APT/STE_____ CITY_____

STATE_____ ZIP_____ EMAIL_____

CELL PHONE_____ WORK PHONE_____

MARITAL STATUS_____ OCCUPATION_____

EMPLOYER_____ EMERGENCY CONTACT_____

RELATIONSHIP_____ PHONE_____

NEW PATIENT INFORMATION

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

— Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, including the release of my medication history from pharmacy records.
— Obtain payment from third-party payers.
— Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Additionally, I give my consent for Sullivan Street Medical and their staff to communicate any issues regarding my health via email and telephone, including leaving messages on the primary phone number I have given.

Patient Name or Surrogate_____

Relationship to Patient_____

Signature_____ Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practice, but was unable to do so as documented below. Reason, date, my name, signature, and title are documented below.

SULLIVAN STREET MEDICAL

NAME:

Reason for visit:

Date of last visit to a doctor:
Who:
For what:
Last time I had a physical:
Primary Care Doctor's name:
Other doctors I see/what for:

Medical problems:

Surgeries (name of procedure/year/surgeon):

Have you spent the night in a hospital? (year/for what/ which hospital):

Medication Allergies:

Medications:

Do you smoke cigarettes? Y N
If yes # per day_____# of years_____?
Former smoker? Y N
When quit? How many years/packs a day?

Average number of alcoholic drinks you consume weekly_____

Do you use recreational drugs? (which ones/how often): Y N
Would you like to discuss reducing your usage/consumption of alcohol and/or drugs? Y N

What do you do for work?

Do you have sex with Men or Women?
# of Male Partners _____
# of Female Partners_____
Do you want to be tested for STDs? Y N

Are your biological parent(s) still alive Y N

Age of Mother_____
Medical problems:

Age of Father_____
Medical problems:

Are any of the following concerning to you:
FEVER — NIGHT SWEATS — RUNNY NOSE
COUGHING — SHORTNESS OF BREATH — WHEEZING
NAUSEA — VOMITTING — DIARRHEA — CONSTIPATION DIZZINESS — FATIGUE — WEAKNESS — FAINTING
SWOLLEN GLANDS — INCREASED THIRST OR HUNGER
CHEST PAIN — PALPITATIONS — HEADACHES
SEIZURES — NUMBNESS — URINARY PROBLEMS
ANXIETY — DEPRESSION — SLEEP — DISTURBANCE
DRY EYES — VISION CHANGES — EAR PAIN
CHANGES IN HEARING — EASY BRUISING — RASHES
DRY SKIN — WEIGHT LOSS — WEIGHT GAIN — HAIR LOSS
DECREASED EXERCISE — TOLERANCE — ABDOMINAL PAIN
MUSCLE PAIN — JOINT PAIN — LEG OR ARM SWELLING
CHANGES IN MOLES — OTHER
(please describe):

Are you depressed? Y N
Do you have thoughts of suicide? Y N
Do you live alone? Y N
With whom do you live?

For Women:
First day of last period:
Date of last GYN exam:
Number of pregnancies: Births:

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(212) 677-6788
179 Sullivan Street, Ground Floor
New York, NY 10012

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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 TODD MCNIFF MD PC (including their agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

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.

My Consent Choice. 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.

☐ **1. I GIVE CONSENT** for TODD MCNIFF MD PC to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for TODD MCNIFF MD PC to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

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

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

SULLIVAN STREET

MEDICAL

CREDIT CARD AUTHORIZATION FORM

We kindly ask that you provide a credit card for us to keep securely on file in your medical record for any of the following circumstances:

— If your insurance carrier denies a claim/ office visit as a non-covered service (in this case wewould reduce the balance to reflect the discounted rate the insurance company would havepaid)

— If at the time of service your insurance was no longer active.

— If your insurance provider holds you responsible for a deductible, co-insurance, or co-pay thatwas not collected on the date of service.

— If any vaccines are not covered by your insurance plan.

We truly value you as a patient and will always try and work with you if you get a large bill from us. **However, it is your responsibility to pay your own bills from our office.** You will first be notified of an outstanding balance that is over 60 days past due by email before we charge your card on file. If you do not respond to the second notice, which will be sent a week later. your card on file will be charged for the full amount owed. If you do not provide a credit card, and do not respond to any outstanding balance correspondences, your balance may be referred to a collections agency, and the practice reserves its right to dismiss you as a patient.

Name on Credit Card: _____

Credit Card Type: _____

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

Billing Address: _____

I guarantee payment of all charges for any medical treatment provided to me.

_____

SIGNATURE of Patient/ Responsible Party

_____

PRINTED Name

_____

Date

179 Sullivan St., Ground Floor, New York, NY 10012 | P 212.677.6788 | F 646.692.8808 | sullivanstreetmed.com

SULLIVAN STREET
MEDICAL

HIV-SPECIFIC MODEL CONSENT FORM

Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

— HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.

— There are treatments for HIV/AIDS that can help an individual stay healthy.

— Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.

— Testing is voluntary and can be done anonymously at a public testing center.

— The law protects the confidentiality of HIV test results and other related information.

— The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.

— The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name or Surrogate_____ Date_____

Signature (Patient or Person Authorized to Consent)_____

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