New York BRCA Center
100 East 77th Street, 3 Wollman
New York, NY 10075
(212) 343-2011
www.BRCAcenter.com

Name **Date**

First Middle Last Today's Date

Address

Street No. City State Zip

Phone

Home Cell

E-mail Address _____

How can we contact you? Please check all that apply (please check more than one if possible).

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail

Gender ☐ Female ☐ Male **Age** _____ **Date of Birth** _____

Occupation _____

Employer Name _____ **Employer Phone** _____

Primary Emergency Contact _____ **Relationship** _____

Phone _____

Secondary Emergency Contact _____ **Relationship** _____

Phone _____

1. Referring Physician _____

Phone _____ **Fax** _____

2. Primary Care Physician _____

Phone _____ **Fax** _____

3. OBGYN _____

Phone _____ **Fax** _____

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How did you hear about the New York BRCA Center? Please check all that apply.

☐ Friend _____ ☐ Relative _____ ☐ Doctor _____

☐ Online _____ ☐ BRCA Group _____ ☐ Other _____

Do you have any specific concerns?

_____

_____

_____

How soon are you interested in receiving treatment?

☐ 1-2 weeks ☐ Next 30 days ☐ 2-3 months

☐ 4-6 months ☐ In the next year ☐ Not sure

If your care requires staying in the hospital overnight are you interested in receiving information about private and luxury room options?

☐ Yes, please let me know about private and luxury rooms at Lenox Hill Hospital

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Health Information as of _____ (Today's date)

Conditions
Do you have or have you had any of the following?

Bruising or bleeding problems?	☐ Yes	☐ No	_____
Problems with scaring?	☐ Yes	☐ No	_____
Wound healing problems?	☐ Yes	☐ No	_____
Problems with anesthesia?	☐ Yes	☐ No	_____
Are you pregnant or nursing?	☐ Yes	☐ No	_____

Medical Issues
List all your medical issues and dates.

_____
_____
_____
_____
_____
_____

Surgeries
List all your surgeries and dates.

_____
_____
_____
_____
_____
_____

Medications
List all medications, frequency, and dose.

_____
_____
_____
_____
_____
_____

Allergies
List all drug and latex allergies.

_____
_____
_____
_____
_____
_____

Family History
List any medical issues in your family.

_____
_____

Have you or a family member ever been diagnosed with a BRCA or other genetic mutation?	☐ Yes ☐ No
Has family member ever been diagnosed with breast cancer?	☐ Yes ☐ No
Has a family member ever been diagnosed with ovarian or fallopian cancer?	☐ Yes ☐ No
Has a family member ever been diagnosed with prostate, pancreatic cancer or melanoma?	☐ Yes ☐ No

Lifestyle

Do you smoke?	☐ Yes	☐ No	How many cigarettes/day? _____ How many years? _____
Do you drink alcohol?	☐ Yes	☐ No	How much and how often? _____
Do you use recreational drugs?	☐ Yes	☐ No	What and how often? _____
Do you exercise?	☐ Yes	☐ No	How often? _____

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Financial Responsibility Form

Name

_____

First Middle Last

Primary Insurance Company

Name of Insurance Co.

_____

Policy No. _____ Member ID No. _____

Secondary Insurance Company

Name of Insurance Co.

_____

Policy No. _____ Member ID No. _____

Insurance Coverage

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.

Insurance Charges

- If you have had any change in your insurance coverage, even if there is only a small change in the co-payment amount or a change in the expiration date of the policy, you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

Coppayments, Co-insurance and Deductibles

- Co-insurance and co-payments are the patient's responsibility. Co-payments are due at the time of the visit.
- Deductibles are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.

Referrals

- It is your responsibility to obtain referrals if required to do so by your plan.

Non-covered Services

- All patients are responsible for "non-covered" services if denied by their insurance carrier.

Insurance Requests

- You are responsible for responding to any requests from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

Insurance Payments Sent to You

- If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

I have read and understand this financial responsibility form.

Patient Signature _____ **Date** _____

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Photo and Video Consent

Name

_____

First Middle Last

I consent to the taking of photographs and/or videos by my physician in connection with surgery, and/or nonsurgical procedure(s).

In accordance with state and federal regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I hereby grant permission for the use of my photographs or other imaging records created in my case, for use in operative planning, examination, testing, credentialing and/or certifying purposes. I also consent to use of my medical records including illustrations, photographs or other imaging records related to my care or surgery for teaching or research purposes, including, but not limited to, presentations at scientific meetings or publication in medical journals, textbooks, websites, electronic media and other media.

I grant consent as a voluntary contribution in the interest of public education and certify that I have read and understand the terms of the above authorization and release. I understand that I can withdraw this consent at any time.

Patient Signature _____ **Date** _____

For Minors: I have read the above Authorization and Release. I am the parent or guardian of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent for the purposes described above.

Parent/Guardian Signature _____ **Date** _____

Print Name

_____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY
Law Requires Us To:
- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the current notice.

We Have The Right To:
- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION
The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.
FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates licensed and credentials we need to serve you.
Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

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Health Oversight Activities: We may disclose medical information to any agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS
You Have a Right to:

- Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge a fee and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- Receive a list of all the times we, or our business associates, shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will aide by our agreement (except in the case of an emergency).
- Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may response with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
- If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

5. QUESTIONS AND COMPLAINTS
If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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Privacy Practices Acknowledgement Form

Name

_____

First Middle Last

I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

Patient Signature _____ **Birthdate** _____

Date _____