ROBERT H. RUBMAN, M.D.,P.C.   720 PARK AVENUE   NY, NY 10021

PATIENT INFORMATION

NAME			REFERRED BY:
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	EMAIL ADDRESS		SOCIAL SECURITY NUMBER ___ ___
HOME PHONE	BUSINESS PHONE		CELLULAR PHONE
SEX ☐ MALE ☐ FEMALE	OCCUPATION		
NAME OF EMPLOYER / SCHOOL			
STREET ADDRESS	CITY	STATE	ZIP CODE
IN CASE OF EMERGENCY, CONTACT:	NAME		PHONE
STREET ADDRESS	CITY	STATE	ZIP CODE

DISCLOSURE INFORMATION

Do we have your permission to:

LEAVE A MESSAGE ON YOUR ANSWERING MACHINE?	☐ YES	☐ NO
AT YOUR PLACE OF EMPLOYMENT?	☐ YES	☐ NO
DISCUSS YOUR MEDICAL CONDITION WITH ANYONE?	☐ YES	☐ NO
IF YES, NAME	RELATIONSHIP	
IF YES, NAME	RELATIONSHIP	
PATIENT'S SIGNATURE ☒		DATE

INSURANCE INFORMATION

Please obtain this information from your insurance ID card or form

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
INSURANCE ID NUMBER	INSURANCE ID NUMBER

"I verify the accuracy of the above information and I authorize payment of medical benefits directly to Robert H. Rubman, M.D., P.C.."	PATIENT'S (OR AUTHORIZED PERSON'S) SIGNATURE ☒	DATE

(The Form Continues on the Reverse Side)

INSURANCE CLAIMS AUTHORIZATION

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my insurance company.

I also authorize my insurance company to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurance company including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators."

MEDICARE (ONLY):

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

PATIENT FINANCIAL LIABILITY STATEMENT

IT IS THE PATIENT'S RESPONSIBILITY TO INFORM US OF THEIR CORRECT INSURANCE.

"I understand that I am personally responsible for charges incurred for services rendered by Dr. Rubman if any of the following apply:"

- **My health benefit plan has an annual deductible, and I have NOT met that deductible.**
- **My health benefit plan requires prior authorization or a referral from my Primary Care Physician (PCP) before receiving services, and I have not obtained an authorization referral.**
- **My health plan determines that the services I receive are in their opinion not medically necessary, and/or are considered routine, and/or are not covered.**
- **My health plan is not one that Dr. Rubman participates in.**
- **My health plan is lapsed or expired at the time of services.**
- **My health plan pays me directly for the claims submitted for Dr. Rubman's services.**
- **I have chosen not to use my health insurance coverage.**

The office accepts assignment: Medicare, AARP, Cigna, Empire Blue Cross Blue Shield, The Empire Plan, GHI, Humana, Oxford, PHCS, United Health Care, Oscar and Magnacare.

We have a 24 hour cancellation policy. Failure to keep your appointment or call and cancel your appointment within 24 hours will result in a $140 charge.

"I agree with the insurance claims authorization and patient financial liability as provided above."	PATIENT'S (OR AUTHORIZED PERSON'S) SIGNATURE	DATE

ROBERT H. RUBMAN, M.D. 720 PARK AVENUE NEW YORK, N.Y. 10021

MEDICAL HISTORY FORM

NAME: **DATE:**

OCULAR HISTORY

PLEASE DESCRIBE YOUR EYE PROBLEM(S) AND REASON FOR TODAY'S APPOINTMENT

DO YOU WEAR GLASSES? Yes ☐ No ☐
Progressives ☐ Trifocals ☐ Bifocals ☐ Readers ☐
Prisms In Your Glasses? Yes ☐ No ☐

DO YOU WEAR CONTACTS? Yes ☐ No ☐

GAS PERMEABLE? ☐ **SOFT?** ☐

CONTACT *Rx*	RIGHT	LEFT
BRAND		
BASE CURVE		
POWER		

HAVE YOU EVER HAD EYE SURGERY? IF YES, PLEASE LIST PROCEDURE(S) AND DATE(S):

DO YOU HAVE A FAMILY HISTORY OF GLAUCOMA, DIABETIC RETINOPATHY, OR OTHER EYE DISEASE?

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY?

CONDITION	CURRENTLY	IN THE PAST	CONDITION	CURRENTLY	IN THE PAST
GLAUCOMA	☐	☐	FLOATERS	☐	☐
EYE INJURY	☐	☐	HALOS	☐	☐
CATARACTS	☐	☐	CHRONIC EYE INFECTION	☐	☐
RETINAL PROBLEMS	☐	☐	EYE PAIN	☐	☐
UVEITIS (IRITIS)	☐	☐	EYE DISCHARGE	☐	☐
FLASHING LIGHTS	☐	☐	EYE ITCHING	☐	☐
THYROID EYE DISEASE	☐	☐	DRY EYE	☐	☐
STRABISMUS	☐	☐	TEARING	☐	☐
AMBLYOPIA (LAZY EYE)	☐	☐	SENSITIVITY TO LIGHT	☐	☐
DIPLOPIA (DOUBLE VISION)	☐	☐	NIGHT BLINDNESS	☐	☐
BLURRED OR FUZZY VISION	☐	☐	OTHER:	☐	☐

CURRENT *EYE* MEDICATIONS	DOSE	FREQUENCY

over

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?					
CONDITION	YES	NO	CONDITION	YES	NO
CARDIOVASCULAR DISEASE	☐	☐	HIGH BLOOD PRESSURE	☐	☐
KIDNEY DISEASE	☐	☐	EPILEPSY OR CONVULSIONS	☐	☐
CARDIOPULMONARY DISEASE	☐	☐	THYROID DISEASE	☐	☐
TUBERCULOSIS	☐	☐	DIABETES	☐	☐
HEPATITIS OR LIVER DISEASE	☐	☐	ARTHRITIS	☐	☐
BLOOD DISORDER	☐	☐	HX STROKE	☐	☐
ASTHMA	☐	☐	OTHER:		
DO YOU SMOKE?	☐	☐	HAVE YOU EVER SMOKED?	☐	☐
FEMALES: PREGNANT?	☐	☐	NURSING?	☐	☐
⇨ HAVE YOU EVER TAKEN OR ARE YOU CURRENTLY TAKING FLOMAX (TAMSULOSIN)?				☐	☐
HAVE YOU EVER HAD A HEART ATTACK? IF YES, PLEASE INDICATE MONTH & YEAR:					
PLEASE LIST ALL ALLERGIES:					
PLEASE LIST ALL PREVIOUS MAJOR SURGERIES:					

CURRENT NON-EYE MEDICATIONS	DOSE	FREQUENCY

PHARMACY (REQUIRED FOR E-PRESCRIBING) / ADDRESS

PHONE NUMBER ( ) -

INTERNIST OR FAMILY PHYSICIAN OR CARDIOLOGIST

PHONE NUMBER ( ) -

PATIENT SIGNATURE:

☒

ROBERT H. RUBMAN, M.D., P.C.
720 PARK AVENUE
NEW YORK, NY 10021
(212) 734-2411

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

This notice of Privacy Practices describes how Robert H. Rubman, M.D., P.C. may use and disclose your Protected Health Information (PHI) in order to carry out treatment, receive payment and for other purposes permitted or required by law. It also describes your rights to access and control your PHI.

Robert H. Rubman, M.D., P.C. is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our office. A copy of our current notice will be available in our reception area. You will also be able to obtain your own copy by calling our office at 212-734-2411 or by asking for one at the time of your next visit. However, we may modify the terms of this Notice at any time, and the new Notice will be effective for all PHI in our possession at the time of the change, and any received thereafter. Upon request, we will provide you with any revised Notice.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with health care. Some examples of protected health information are:

- Information indicating that you are a patient of our practice or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation or a diagnostic test); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number or your phone number); or
- other types of information that may identify who you are.

REQUIRED PERMISSIONS TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Robert H. Rubman, M.D., P.C. uses PHI about you for treatment and to receive payment. We will obtain a one-time general written consent to use and disclose your PHI in order to treat you, obtain payment for that treatment, and conduct business operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

We will generally obtain your written authorization before using your health information or sharing it with others outside of our practice. You may also ask that we provide information or transfer your records to another person by completing a written authorization form. If you provide us with written authorization,

you may revoke that written authorization at any time, except to the extent that we have already relied upon it or taken action to do what you asked us to do. To revoke a written authorization, please write to our Privacy Officer at our office address listed above.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment, Payment and Business Operations

With your general written consent, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payer. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. Dr. Rubman and his staff may share your health information with each other for the purpose of treating you. Dr. Rubman may also share your health information with a doctor or other healthcare provider outside of our practice as part of your diagnosis and treatment. Dr. Rubman may also share your health information with another doctor to whom you have been referred for further health care. Dr. Rubman may also share your health information with another doctor from whom your have been referred, for the purpose of reporting back on your condition.

Payment. We may use your health information or share it with others so that we can obtain payment for your health care services. For example, we may share information about you with your health insurance company(s) in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company(s) about your health condition in order to obtain pre-approval for your treatment, such as admitting you to a hospital for a particular type of surgery. We may use and disclose your health information to obtain payment from third parties that may be responsible for such costs. Finally, we may share your information with other health care providers who have treated you so that they also can have accurate information to seek payment form your health insurance company or managed care plan.

Business Operations. We may use your health information or share it with others in order to conduct our office's business operations. We may share your health information with other health care providers and with your health insurance company or managed care plan for certain of their business operations if the information is related to a relationship the provider or payer currently has or previously had with you, and of the provider or payer is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates. We may disclose your health information to our contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us obtain information from your insurance company or a collection agency, which collects overdue payments. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

We can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that we have already relied upon it. For

example, if we provide you with treatment before your revoke your general written consent, we may still share your health information with your insurance company in order to obtain payment for that treatment. To revoke your general written consent, please write to our Privacy Officer at the address listed above.

II. Emergencies or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your general written consent before using or disclosing your information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct business operations if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent. If this happens, we will try to obtain your general written consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use and disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct business operations if we are unable to obtain your general written consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

As Required by Law. We may use or disclose your health information if we are required by law to do so. We will also notify you of these uses and disclosures if notice is required by law.

Public Health Risks. Robert H. Rubman, M.D., P.C. may disclose your PHI to public health authorities (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease of a law permits us to do so.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that your have been a victim of such abuse, neglect or violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. Robert H. Rubman, M.D., P.C. may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Product Monitoring, Repair and Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Similar Proceedings. Robert H. Rubman, M.D., P.C. may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- Concerning a death we believe might have resulted from criminal conduct;
- Regarding criminal conduct at our office;
- In response to a warrant, summons, court order, subpoena or similar legal process;
- To identify and/or locate a suspect, material witness, fugitive or missing person; and
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

Serious Threats to Health or Safety. Robert H. Rubman, M.D., P.C. may use and disclose your PHI when necessary to reduce or prevent a serious threat to your heath and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Robert H. Rubman, M.D., P.C. may use and disclose your PHI if you are a member of United States or foreign military forces (including veterans) and if required by the appropriate military command authorities.

National Security. Robert H. Rubman, M.D., P.C. may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates. Robert H. Rubman, M.D., P.C. may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary : (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of others.

Worker's Compensation. Robert H. Rubman, M.D., P.C. may release your PHI for workers' compensation and similar programs.

Coroners, Medical Examiners, and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information for research without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our office. If the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

III. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of , your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because the will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. The Right to Inspect and Copy

You have the right to inspect and obtain a copy of any of your PHI that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. To inspect or obtain a copy of your health information, please submit your request in writing to our Privacy Officer. If you request a copy of the information, we will charge you a fee for the costs of copying, mailing, labor and supplies associated with your request. The standard fee is $0.75 per page and must generally be paid before or at the time we give the copies to you. We will respond to your request for inspection of records within 10 business days. We ordinarily will respond to requests for copies within 30 days if the information is located at our office, and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the timeframe above to explain tie reason for the delay and when you can expect to have a final answer to your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of our rights to have that decision reviewed and how you can exercise those rights. The notice will also include information of how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. The Right to Amend your PHI

If you feel that any PHI we have about you is not correct or is incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by Robert H. Rubman, M.D., P.C. To request an amendment, your request must be made in writing to our Privacy Officer. Additionally, you must provide a reason that supports your request. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

Robert H. Rubman, M.D., P.C. reserves the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by Robert H. Rubman, M.D.,P.C, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Robert H. Rubman, M.D., P.C.;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right to an Accounting of Disclosures

After April 14, 2003, you have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared between health care providers at our office or with other health care providers outside our practice, as long as all other protections described in this Notice of Privacy Practices have been followed.
An accounting of disclosures does not include information about the following disclosures:

- Disclosures we made to your or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; and
- Disclosures made before August 14, 2003.

To request an accounting of disclosures, please write to Privacy Officer. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting within every 12-month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run are business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care or payment for your care. For example, you could request that we not disclose information about a surgery you had. To request that we not disclose information about a surgery you had. To request restrictions, please write to the Privacy Officer. Your request should include (1) what information you want to limit; (2)

whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, please write to the Privacy Officer. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

6. Right To Have Someone Act On Your Behalf

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

7. Right To Obtain A Copy Of Notices

If this notice is provided electronically, you have the right to a paper copy of this notice, which you may request at any time. To do so, please call our office at 212-734-2411. You may also obtain a copy of this notice by requesting a copy at your next visit. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. We will post any revised notice in our office reception area. You will also be able to obtain your own copy of the revised notice. You will also be able to obtain your own copy of the revised notice. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

8. Right To File A Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Office at 212-734-2411. *No one will retaliate or take action against you for filling a complaint.*

9. How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV/AIDS-related information, mental health information and psychotherapy notes. Some parts of this general Notice of Privacy Practices may not apply to these types of information. To request a Notice of Privacy Practices that pertains to those types of health information, please contact our Privacy Officer.

Acknowledgement And Consent

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

____

Signature of Patient or Patient's Personal Representative

____

Print Name of Patient or Patient's Personal Representative

____

Date

____

Description of Personal Representative's Authority