VIJAYPAL ARYA PHYSICIAN PC

75-17 Metropolitan Ave., Middle Village, NY 11379
Ph: 718-326-0400 Fax: 718-326-0285 Web: www.aryagastro.com

PATIENT REGISTRATION

LAST NAME: _____FIRST NAME: _____MI: _____

SS#_____ DOB_____ SEX: MALE FEMALE

STREET ADDRESS_____ APT#_____

CITY/STATE_____ ZIP CODE_____

TEL # HOME_____WORK_____CELL/BEEPER _____

E-MAIL_____ ____ ETHNICITY_____

MARITAL STATUS (circle one) Single Married Separated Divorced

How do you like to be contacted E-mail Phone Mail

Preferred Pharmacy Name: _____ Add: _____ Zip: ____

REFERRED BY: Dr. _____TEL#_____

ADDRESS_____

INSURED INFORMATION (if not patient)

NAME: _____RELATIONSHIP TO PATIENT_____

DATE OF BIRTH_____ SS# _____

TEL#_____STREET ADDRESS_____

CITY/STATE_____ZIP CODE_____

PRIMARY INSURANCE_____ID#_____

SECONDARY INSURANCE_____ID#_____

Emergency contact: _____Relationship_____ Tel #_____

Employer Name_____ Tel# _____Ext # _____

Employer Address_____

Patient's Occupation_____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

I hereby authorize Dr. Vijaypal Arya to apply on benefits on my behalf for covered services rendered by him/her or by him/her. I request that payment from my insurance company be made directly to Dr. Vijaypal Arya (or to the part who accepts assignment).

I certify that the information I have reported with the regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____ _

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CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Phone: Fax: E-Mail:

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Notice Of Privacy Practices: Use And Disclosure Of Health Information Protected Under HIPPA

This document provides a summary of how medical information about you may be used and disclosed and how you can obtain access to this information.

We understand that medical information about you and health is personal. We are committed to protecting your medical information. It is our policy that the privacy of your protected health information (PHI) be uncompromised while still allowing necessary access to assure that the medical care you receive is appropriate and of the highest possible quality.

We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operation (TPO):

1. To provide medical treatment and/ or services.
2. To bill third party payers, when appropriate, for treatment you receive from us.
3. To facilitate the mechanisms, which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation, which created these privacy practices. We recognize that all patients have right to privacy in matters relating to their health and we will not use your PHI for uses outside of our facility without your express permission.

You have the following rights regarding to the medical information we maintain about you:

1. To inspect and copy information that may be used to make decisions about your care.
2. To request restrictions or limitations on the medical information we use or disclosure about you for treatment, payment, or health care operations. While we are not required to agree to your request, we will do our utmost to comply unless the information is needed to provide emergency treatment.
3. To amend the PHI we maintain if you believe that the medical information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request a confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be applicable to all patients.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the state oversight department; all complaints must be submitted in writing. You will not penalized for filing a complaints.

Patient acknowledgement:

I acknowledge receipt of this information regarding my right to PHI privacy.

Patients Name: _____

Signature: _____

Date: _____

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DISCLOSURE

Welcome to the Vijaypal Arya Gastroenterology PC, which is owned by Vijay Arya MD.

We would like you to know that Dr. Vijaypal Arya is board certified by the American Board of Internal Medicine and is licensed in the State of New York. He has been in practice for 22 years and you may request his C.V., which we keep on file. Should you choose to have surgery at this organization, Dr. Vijaypal Arya will be the only one performing your surgery.

Additionally, this organization utilizes Board Certified credentialed anesthesia providers, with 12 years of experience. Our anesthesiologist is Dr. Kalpana Arya-Gupta certified by American board of Anesthesiologist and has training licensed in the State of New York.

This organization also uses credentialed and licenced in the New York State, mid- level providers of care, i.e. Physician Assistant. They provide care according to their scope of service.

This practice educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage everyone to cover their mouth when coughing or sneezing and then wash their hands. Should you have a procedure or surgery in this organization we want you to know that we value patient safety. Therefore you may hear us performing certain tasks or asking certain questions that may surprise you. Even though we may know you we will ask you identifying information such as your date of birth or your address besides asking you to tell us your name. We take a pause or a "time out" before we actually start your procedure to assure one again that we have everything that we need and the entire team is in agreement. This organization adheres to strict infection control measures before during and after your procedure including but not limited to: procedural technique, the environment of care, care of equipment and instruments, and education of all staff in the most up to date infection control measures.

Please be advised that if you have a grievance the following mechanism exists: ask for grievance from the receptionist.

If you have a suggestion, please place this in writing, can be anonymous and hand to the receptionist or mail it to the office.

Additionally, please be advised that this organization does not recognize Do Not resuscitate orders or living wills. If you have any questions, please see the receptionist.

I have received information regarding the providers of care in this organization.
I have received a copy of the Patient's Bill of Rights and Responsibilities.
I have received information regarding the grievance process.
I have received information regarding the speak-up program.
I have received information regarding the infection control process of this organization and I understand this information OR I do not understand this information

Patients Name: _____

Signature: _____

Date: _____