CANANDAIGUA TRINITY OB/GYN PLLC

Hani Chehata, MD, MBCHB, FACOG, FRCOG

PATIENT MEDICAL RECORDS RELEASE

Please release my medical records to:

Dr. Hani Chehata
Canandaigua Trinity, LLC
241 Parrish Street
Canandaigua, New York
Phone (585) 337-4335 Fax (585) 337-4336

____
Name of Person/Entity Releasing Patient Record

____
Person/Entity Address

This disclosure is being made at the request of the patient, their authorized health care proxy, or their legal representative.

I understand that if the person or entity that receives this information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations.

This authorization expires one (1) year after the date of the signature below.

I understand that a written notification is necessary to cancel this information. To obtain information how to withdraw my authorization or to receive a copy of my withdrawal request, I must contact Canandaigua Trinity, LLC. I am aware that my withdrawal will not be effective on any actions the requesting entity took before they received written notification of my withdrawal.

A photocopy of this Authorization is to be considered as valid as the original.

______________________________ ______________
Patient's Signature (Printed) Birthdate

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Witness Signature Date

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PATIENT'S BASIC INFORMATION

DATE

Name	Date of Birth	Social Security #
Marital Status	Sex	Race
Address	City	Zip Code
Home Phone	Cell Phone	Work Phone
May we leave a message on your phone?	May we talk to someone else about your care?	If yes, name of that person/relationship

YOUR EMAIL ADDRESS: ______________________________

EMERGENCY CONTACT

Contact name	Relationship	Phone Number

PHARMACY

Pharmacy Name	Pharmacy Address
Pharmacy Phone Number	Employer (self)
Employer (spouse)	

WHO REFERRED YOU TO THIS OFFICE?

CANANDAIGUA TRINITY OB/GYN PLLC

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INSURANCE INFORMATION

DATE________________

PRIMARY INSURANCE	SUBSCRIBER	DATE OF BIRTH
PRIMARY INSURANCE ID#	PRIMARY INSURANCE GROUP #	PLAN
SECONDARY INSURANCE	SUBSCRIBER	DATE OF BIRTH
SECONDARY INSURANCE ID#	SECONDARY INSURANCE GROUP #	PLAN

I understand that I am responsible for the full cost of services rendered today if:

1. I have HMO insurance but fail to list a group doctor as my Primary Care Physician (PCP)

   OR

2. I fail to obtain a referral when necessary. I understand that the practice will bill me for any balance for which I am personally responsible.

I certify that the above personal and insurance information is correct.

________________________________ ________________

Patient signature Date

Receiving staff member has checked that the information is legible, complete and verified via HealtheNet or other source.

________________________________ ________________

Staff signature Date

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HEALTH AND HISTORY

Patient Name ______________________ Date of Birth ______________________

SURGERIES (List any surgery you have had in your lifetime)

Type of Surgery	Year of Surgery

MEDICATIONS (List any and all medications you are currently taking (including over the counter, vitamins, inhaler). State the dose and the frequency of use.

Medication	Dose (mg)	How Many Times a Day?

ALLERGIES (MEDICATION)

Medication	Reaction

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ALLERGIES (FOOD, ENVIRONMENTAL AND SUBSTANCES)

Food, Environmental, Substances	Reaction

FAMILY HEALTH HISTORY (If your relatives are living, list their age and any health problems they have. If deceased, please list age when deceased and cause of death, if known)

Relative	Health Issues	Age/ Death (if deceased)
Mother		
Father		
Sibling(s)		
Other:		

TESTS (List when you had the test last)

Tests	Year Last Taken
Mammogram	
Breast self-exam	
Pap/Pelvic exam	
Colonoscopy	
EKG	
DEXA (bone-density exam)	
Eye Exam	
Blood Test	
Cardiac Stress Test	
Hearing Evaluation	
Yearly Physical	

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IMMUNIZATION (when did you last have the following immunization done?)

Shots	Month/Year
Flu	
Pneumonia	
Tetanus	

* Flu and pneumonia shots should be taken every year. Tetanus every 10 years

Childhood Immunization Records	Year
Measles	
Mumps	
Rubella	
Chicken Pox	
Polio	
Rheumatic Fever	
Whooping Cough	

SOCIAL HISTORY

Are you married? Y N What is your occupation? ____________

Do you smoke? Y N If yes, how many packs per day? ____________

How long have you smoked? ____________

If you quit, how long ago? ____________

Do you drink alcohol? Y N If yes, how many drinks and how often? ____________

Do you exercise? Y N If yes, how often? ____________

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name ______________________________ Date ________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several Days	More than Half days	Nearly everyday
1.	Little interest or pleasure in doing things	__0__	__1__	__2__	__3__
2.	Feeling down, depressed or hopeless	__0__	__1__	__2__	__3__
3.	Trouble falling or staying asleep, or sleeping too much	__0__	__1__	__2__	__3__
4.	Feeling tired or having little energy	__0__	__1__	__2__	__3__
5.	Poor appetite or overeating	__0__	__1__	__2__	__3__
6.	Feeling bad about yourself-or that you are a failure or have let yourself or your family down.	__0__	__1__	__2__	__3__
7.	Trouble concentrating on things, such as reading the newspaper or watching television	__0__	__1__	__2__	__3__
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	__0__	__1__	__2__	__3__
9.	Thoughts that you would be better off dead, or of hurting yourself in some way.	__0__	__1__	__2__	__3__

Columns Totals ______ + ______ + ______

Add Totals Together ____________

[illegible]

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PATIENT PRIVACY POLICY STATEMENT AND SIGNOFF

CANANDAIGUA TRINITY, LLC is committed to maintaining the privacy of your Protected Health Information (PHI) which includes information about your health condition and the care and treatment you receive from this practice. The formation of a record detailing the care and services you obtain helps this office to provide you with exceptional quality health care. This notice details how your PHI may be used and disclosed to third parties. This document also details your rights concerning your PHI.

Canandaigua Trinity, LLC may use and/or disclose your PHI for the following purposes:

a) **Treatment**: Canandaigua Trinity, LLC may provide your PHI to those health care officials directly involved in your care so that they may understand your health condition and needs.

b) **Payment**: In order to obtain payment for services provided to you, Canandaigua Trinity, LLC will provide your PHI directly or through a billing service to appropriate third parties, pursuant to their billing and payment requirements.

c) **Health Care Operations**: It may be necessary for the practice to compile, use, and/or disclose your PHI in order for Canandaigua Trinity, LLC to operate in accordance with applicable law and insurance requirements and in order for the practice to continue to provide quality and efficient care.

CANANDAIGUA TRINITY, LLC may also use and/or disclose your PHI without your specific authorization in the following additional instances:

a) **De-identified Information**: Information that does not identify you.

b) **Business Associate**: An entity that assists Canandaigua Trinity, LLC in undertaking some essential function.

c) **Personal Representative**: A person who represents you in making health care decisions.

d) **Emergency Situations**

e) **Law and Government Authorities**: All government and legal authorities to whom we are obliged by law to provide your information.

f) **Coroner or Medical Examiner**

g) **Organ, Eye, Tissue Donation**: Applies to those who are organ, eye, or tissue donors.

h) **Averting a Threat to Health or Safety**

i) **Workers Compensation**

Above are the major categories. To see a detailed and complete list, please see Department of Health and Human Services website ([illegible]).

FAMILY AND FRIENDS

CANANDAIGUA TRINITY, LLC may disclose to your family members, other relatives, a close personal friend or any other person identified by you, your PHI directly relevant to such persons' involvement with your care. All such disclosures are subject to our professional judgment.

AUTHORIZATION

Uses and/or disclosures other than those described above will be made only with your written authorization.

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Your Rights

You have the right to:

a) Remove any authorization in writing at any time.
b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, Canandaigua Trinity, LLC is not obligated to agree to any requested restrictions.
c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the practice's Privacy Officer. The practice will accommodate all reasonable requests.
d) Inspect and copy your PHI as provided by law.
e) Request an amendment to your PHI as provided by law.
f) Receive any copy of this Privacy Notice from Canandaigua Trinity, LLC or the Secretary of HHS ( ) if you believe your Privacy Rights have been violated.

To obtain more information or have your questions about your rights answered you may contact the practice's Privacy Officer.

Responsibilities

CANANDAIGUA TRINITY, LLC acknowledges and affirms that it:

a) Is required by Federal law to maintain the privacy of your PHI and to provide you with a Privacy Notice detailing Canandaigua Trinity, LLC's legal duties and privacy practices with respect to your PHI.

b) Is required by New York State law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is set forth by Federal law.

c) Is required to abide by the terms of this Privacy Notice.

d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

e) Will made readily, available to you any revised Privacy Notice prior to implementation.

f) Will not retaliate against you for filing a complaint.

For a full list and description of your rights, please go to or call (888) 827-7748.

By signing below, I certify that I have received and reviewed the Canandaigua Trinity, LLC Patient Privacy Policy and all of my questions have been answered to my satisfaction in language that I can understand.

____
Patient's Signature

____
Patient's Name (Printed)

____
Date

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FINANCIAL POLICIES

Thank you for choosing our practice as your health care provider. We are committed to provide a successful physician-patient relationship with you and your family. A clear understanding of our financial policies is important to our professional relationship. Any questions about our fees, our policies is your responsibility to notify our billing company, Athena.

Co-pays and Past-due Balances

All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit card. Absolutely no post-dated checks will be accepted. There is an additional $10.00 charge fee for billing a co-pay.

Insurance Claims

Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurances, as well as any change of insurance information. Failure to provide a complete insurance information may result in patient's responsibility for the entire bill. If you have claim forms we can help you with them, but we may need to charge an additional fee for working on them if you do not bring them with you at the time of your office visit. Although, we may estimate what your insurance company may pay. It is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for services performed at our office or you do not have insurance coverage, you will be responsible for the complete balance of the non-payable services ("self-pay"). If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Missed Appointments

We require 24-hour notice of appointment cancellation. Appointments missed without cancellation may be charged a "no-show" fee of $50.00.

Returned Checks

The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

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Outstanding Balance Policy

It is our office policy that all past-due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and a possible discharge from a practice or a wage of garnishment may be imposed.

In event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs as well as a 33% collection fee.

Regardless of any personal arrangements that a patient might have outside our office. If you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I, ______________________________ have read the above summary of financial policies and understand my financial responsibility to my healthcare provider.

______________________________ ______________

Patient Signature Date

______________________________ ______________

Witness Signature Date

CANANDAIGUA TRINITY OB/GYN PLLC

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PATIENT SELF-PAY POLICY

I, ____ understand that payment for listed services is due on the day of my appointment and will make payment prior to leaving the office.

I am aware if payment is not made on the day of service, I will be held responsible for the full charge and will take all necessary action to recoup payment of any and all balances.

____ ______________________________
Patient Signature Date

____ ______________________________
Staff Signature Date

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ADVANCE DIRECTIVE DECLARATION

I, ______________________________ being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of dying if I should be in terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment:

I DO	I DO NOT	
		want cardiac resuscitation
		want mechanical respiration
		want feeding tube
		want other artificial or invasive form of nutrition (food)
		want other artificial or invasive form of hydration (water)
		want blood or blood products
		want any form of surgery
		want any invasive diagnostic tests
		want kidney dialysis
		want antibiotics
		want (other) ______________________________

I realize that if I do not specifically indicate any preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

I DO	I DO NOT	
		want to donate my organs upon death
		want to designate a surrogate to make medical treatment decisions for me if I should be incompetent in a terminal condition or in a state of permanent unconsciousness.

Surrogate name and address: ______________________________

Substitute surrogate name and address: ______________________________

____
Patient Signature

____
Date of Declaration

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The above named individual or a person on behalf of and at the direction of the individual knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness Signature	Address

The above named individual or a person on behalf of and at the direction of the individual knowingly and voluntarily signed this writing by signature or mark in my presence.

CANANDAIGUA TRINITY OB/GYN PLLC
241 Parrish Street - Suite B
Canandaigua, New York 14424-1784
Phone: (585) 337.4335 Fax: (585) 337.4336
Hani Chehata, MD, MBCHB, FACOG, FRCOG

HEALTH CARE PROXY

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent, the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example you could say:

If I become terminally ill, I do/don't want to receive the following treatments.....
If I am in a coma or unconscious with no hope of recovery, I do/don't want ....
I have discussed with my agent my wishes about ....and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below: (this is not a complete list of the treatments about which you may have instructions).

* artificial respiration
* abortion
* blood transfusions
* artificial nutrition and hydration
* electric shock therapy
* antipsychotic medication
* sterilization
* psychotherapy
* antibiotics
* cardiopulmonary resuscitation (CPR)
*transplantation
* dialysis

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You can choose any adult (over 18), including a family member or a close friend to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor. A physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

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HEALTH CARE PROXY

I, ____ hereby appoint:

____

(Name) (Home Address)

____

(Phone number)

as my health care agent to make and all health care decisions for me, including decisions about artificial nutrition and hydration, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

Name of substitute or fill-in if the person I appoint above is unable, unwilling or unavailable to act as my health care agent:

____

Name Home Address

____

Phone number

____

Instructions (optional)

I direct my agent to make health decisions in accord with my wishes and limitations as stated below or as he or she otherwise knows. (Attach additional pages if necessary).

____

____

____

____

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration).

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Unless I revoke, this Proxy shall remain in effect indefinitely, or until the data or conditions stated below. This Proxy shall expire (specific date or conditions, if desired):

____

______________________________________ ______________________
Patient Signature Date

____
Patient Address

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his/her own free will. He/she signed (or asked another to sign for her/her) this document in my presence.

____
Witness 1

____
Address

____
Witness 2

____
Address