In Touch With Your Health

Lynda Varlotta, D.O.

Holistic Medical Practice ~ Osteopathic Medicine ~ Family Physician ~ Trigger Points
Medical Marijuana/Educator ~ Cranial Osteopathy ~ Nutrition ~ Pet Therapy ~ Bio-Identical Hormones

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PATIENT INFORMATION FORM

Section 1: Please provide for my office to copy: 1. Insurance Card(s) 2. Driver's License 3. Credit Card

Section 2: Patient Information

Name_____

Address_____

_____

Home phone number _____Cell phone number _____

E-mail address_____

DOB_____ Age_____

Employer / School_____

Pharmacy Name & phone number _____

Section 3: In Case of an Emergency, who should we notify?

1. Name _____

   Relationship_____

   Home phone number _____Cell phone number _____

2. Name _____

   Relationship_____

   Home phone number _____Cell phone number _____

Sign_____Date_____

1501 Stony Brook Road, Stony Brook, NY 11790
www.InTouchHealth.net
Phone: 631.689.2846 | Fax: 631.675.0170
email:DrV@InTouchHealth.net

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CONFIDENTIAL
Initial Assessment & Patient History

Today's Date_____ Name_____ Age_____ Birthdate_____

Medical Allergies _____

Food Allergies_____

Past Medical History

Year_____Diagnosis_____ Hospitalization?_____

Year_____Diagnosis_____ Hospitalization?_____

Year_____Diagnosis_____ Hospitalization?_____

Year_____Diagnosis_____ Hospitalization?_____

Date of last physical_____ Date of last cholesterol screen_____

Date of last pap_____ Date of last breast exam_____

Date of last mammogram_____ Date of LMP_____

Date of last colonoscopy_____ Date of transfusion (if any) _____

Date of last prostate exam_____ Date of last physical _____

Medications_____

_____

Supplements_____

_____

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Today's Date_____ Name_____

Past Surgical/Procedure History

Year_____ Diagnosis_____

Year_____ Diagnosis_____

Year_____ Diagnosis_____

Year_____ Diagnosis_____

Pregnancy History

Year of pregnancy/birth_____ Sex _____ Complication?_____

Year of pregnancy/birth_____ Sex _____ Complication?_____

Year of pregnancy/birth_____ Sex _____ Complication?_____

Year of pregnancy/birth_____ Sex _____ Complication?_____

Social History

How Much? Tobacco _____ Alcohol _____ Caffeine_____

Occupation _____ Marital status (circle) S M W D

Do you own a gun?_____ Do you have a gun license? _____

Do you Have a history of drug addiction? _____ For how long?_____

Are you recovered?_____ For how long?_____

Do you use recreational drugs?_____ What do you use?_____

Are you being treated for mental health issues? _____ Have you in the past?_____

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Today's Date_____Name_____

Symptoms (Please circle)

Fever - Chills – Dizziness – Fainting - Headache – Poor Memory - Difficulty Falling Asleep - Difficulty Staying Asleep - Weight Loss - Weight Gain – Eating More – Eating Less – Eating Same - Anxiety - Depression Hot Flashes - Night sweats – Cold all the time – Hair Loss – Weight Gain

Pain – weakness – numbness – which areas or joints?_____
_____

Frequent urination - waking up to urinate at night - blood in urine – painful urination – lack of bladder control – bowel changes - constipation – diarrhea – gas - nausea – rectal bleeding – stomach pain – vomiting

Chest pain – irregular heart beat – poor circulation – poor circulation – swelling of ankles

Bleeding gums – blurry vision – vision with halos - difficulty swallowing – ear ache – loss of hearing – sinus congestion – nose bleeds – cough - ringing in ears

Bruise easily – hives – itching – change in moles – rash – scars – wound not healing

Men: breast lump – erectile dysfunction – poor libido – lump in testicles – penile discharge – sore on penis

Women: Poor libido, bleeding between periods – breast lump – menstrual pain – hot flashes – vaginal discharge – vaginal dryness – breast tenderness – painful intercourse

Family History: (please specify of grandparent, parent, aunt, uncle, brother, sister)

Diabetes _____ Thyroid disorder_____

Heart Attack _____ Arthritis_____

Cancer_____

Depression/Anxiety_____ AIDs _____

Asthma _____ Hepatitis _____

Sign_____Date_____

HIPAA PRIVACY NOTICE

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information

Your medical information is private and confidential. The office of Lynda Varlotta D.O. is required by law to maintain the privacy of "protected health, information." "Protected Health Information" includes any individually identifiable information we obtain from you or others that relates to your past, present or future physical or mental health the healthcare you have received or payments made for your health care.

As required by law, this notice provides you with the information for purpose of treatment payment and healthcare operations. For each of these categories of uses and disclosure, there is a description and example below. Please note that every particular use or disclosure in every category will be listed.

TREATMENT means the provision, coordination, or management of your health care including consultations between health care providers regarding your care and referrals from one health care provider to another. For example, the doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen most suitable to your needs.

PAYMENT means the activities we undertake to obtain reimbursement for the health care provided to you. This includes billing collections and claims management determinations of eligibility, and coverage and utilization review activities. For example prior to providing health care services, we may need to impart information to your Third Party Payer about your medical condition to determine whether the proposed course of treatment is covered. When we subsequently bill the Third Party Payer for services rendered to you, for payment purposes, we may provide the Third Party Payer with information regarding your care. Prior to disclosing this information, we will ask you to sign a written release form.

Sign_____Date_____

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FINANCIAL AGREEMENT

Insurance is accepted as payment for covered procedure. I (please print) _____ am responsible for any co-insurance, deductible, non-covered procedures or if my insurance company denies services as not medically necessary. Any insurance check I receive for all services will be endorsed and forwarded to the doctor along with the Explanation of Benefits within 45 days from the date they are issued by my insurance company. All balances must be paid within 3 months after the insurance payment is received by the office or by myself and if not paid, a $10.00 per month late fee and/or collection costs and legal fees of 20% of total amount owed will be added to the balance.

Sign_____Date_____

I, _____, am aware that Dr. Lynda Varlotta is an out-of-network physician and insurance companies and plans vary. Therefore, it is my responsibility to understand my plan and its out-of-network benefits as there might be a balance on my part due to out-of-network deductible and co-insurance. I understand that physician and staff cannot predict how claims are processed until Explanation of Benefits is received. ALL EOBs, (Explanations of Benefits) including those without checks attached, received by the insured ought to be forwarded to the physician.0

Sign_____Date_____

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OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Lynda Varlotta, D.O. | 1501 Stony Brook Road, Stony Brook, NY 11790 | Fax # 631-675-0170

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **X-Ray, MRI, CT-Reports, Medication Summary, Diagnosis SUMMMARY**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.