
CHARLES SAHA, MD, P. C.
REGISTRATION FORMS

Charles Saha, MD

Akifa Samdani, MD

Today's Date: _____

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City, State, Zip: _____ Apt # _____

Home Phone: _____ Cell Phone: _____

Email (Required): _____

Please Print

Emergency Contact: _____ Ph# _____

Relation: _____

Employer: _____ Work Phone: _____

Position: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone # _____

Pharmacy Full Address with Zip Code: _____

**** PLEASE NOTE: PRESCRIPTIONS WILL BE SENT TO CAPSULE PHARMACY IF NO PHARMACY IS LISTED**

INSURANCE INFORMATION

ID Card and Insurance card are required and must be presented to the front desk upon arrival

Primary Insurance Name: _____ Member ID# _____ Group# _____

Subscriber Name: _____ Date of Birth: _____

CHARLES SAHA, MD, PC
120 East 86th Street, Suite MCS, New York, NY 10028
Ph: 212 427 1898 Fax: 866 234 2243

AGREEMENT OF FINANCIAL RESPONSIBILITY

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance, or any other balance not paid by your insurance. In order to control the cost of billing, we request that copays and other services rendered by our office not covered by insurance be paid upfront upon checking in for each visit. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collection. This assignment will remain in effect until revoked by me in my writing. A photocopy of the assignment is considered to be ad valid as the original.

*** I understand that I am financially responsible to pay for all charges whether or not paid by insurance. Patient Initials _____

*** Authorization to pay benefits to Physician: I hereby authorize payment directly to the physician of any benefits, otherwise payable to me for his/her services realizing I am responsible to pay non-covered services. Patient Initials _____

*** I agree to the assignments and financial responsibilities as indicated on this form. Patient initials _____

Patient Name/Patient Representative _____
(Please Print)

Signature of Patient/Patient Representative _____

Today's Date: ____/____/____

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**CONSENT FOR RELEASE OF INFORMATION FOR
TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I, _____, hereby authorize Charles Saha, MD, PC to use and disclose my health information which specifically identifies me or which can be seasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Charles Saha, MD, PC can refuse to treat me.

I have been informed that Charles Saha, MD, PC has prepared a notice with more fully describes the uses and disclosures that can be made of my individual identifiable health information for treatment, payment and healthcare operations.

I understand that I may revoke this consent at anytime by notifying Charles Saha, MD, PC in writing but if I revoke my consent, such revocation will not affect any actions Charles Saha, MD, PC took before receiving my revocation.

I understand that Charles Saha, MD, PC have reserved the right to change his/her privacy practices and that I can obtain such changes notice upon request.

I understand that I have the right to request that Charles Saha, MD, PC physicians restrict how my individually identifiable health information is used and or/disclosed to carry out treatment, payment or health care operations. I understand that Charles Saha, MD, PC physicians do not have to agree to such restrictions, but once such restrictions are agreed to Charles Saha, MD, PC must adhere to such restrictions.

Patient Name/Patient Representative: _____
(Please Print)

Patient/Patient Representative Signature: _____

Today's date: ____/____/____

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CONSENT FOR EMAIL CORRESPONDENCE OPTIONAL

Charles Saha, MD, PC staff members choose to correspond with patients through email if the patient agrees to email communication. You do not have to sign this section if you do not want to correspond with CSMDPC staff members through email. Signing this section does not guarantee that CSMDPC providers will contact you via email

By signing this form, I grant my consent for CSMDPC to use email as a form of correspondence between CSMDPC and myself. If an email has not been answered, I understand it is my option to make an appointment with the healthcare provider. I understand that CSMDPC may use this form of communication at any time for any reason. Furthermore, I understand that I have no expectation of privacy while corresponding through email. The use of email with a CSMDPC provider may revoke or cancel any expectation of privacy afforded by Doctor-Patient privilege and may jeopardize any privacy or expectation of my care under no circumstances should I rely on email in an emergency situation.

Charles Saha, MD, PC may send my PHI to my email address which is:

REQUIRED IF YOU WANT EMAIL CORRESPONDENCE

Signature of Patient: _____

Date: ____/____/____

PRACTICE CONFIDENTIALITY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I _____ understand that my signature below gives Charles Saha, MD, PC (CSMDPC) permission to the extent necessary to use my medical records and to provide access to my medical record while and after I am treated by CSMDPC for the reasons that follows.:

1. For the purpose of providing treatment to me. This would include, for example: sharing information with employees and contractors of CSMDPC, or with other health care providers who are treating me or consulting in my care.
2. For the purpose of arranging payment for my care. This will include, for example, my insurer or other third-party payer who is responsible for paying all or part of my cost of care.
3. For the purpose of CSMDPC's "health care operations" This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.
4. For the purpose of other health care providers "health care operations" to the extent that they have a treatment relationship with me. I understand that CSMDPC may be required by law, in some cases, to make disclosures of my record that I have not authorized. Examples are subpoenas in criminal or civil litigations or request/surveys by licensure agencies or the U.S. Department of Health and Human Services.

I understand that my permission allows CSMDPC to transmit permissible information through any means that is reasonably secure including via email, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time but CSMDPC may refuse to give me further treatment if I do so. I also may request a Specific Authorization for Release of Medical Records that I may sign that authorized CSMDPC to make specific disclosure that is not covered under sections 1-4 above. A Specific Authorization will name the part to whom I am authorizing disclosure and will contain any limitations on the authority to disclose my records.

I understand that I have the right to request that CSMDPC restricts how my medical information is used. If I wish to request a restriction I will initial the following box: _____. In this case, CSMDPC will give me a separate form for me to fill out which will also be used for CSMDPC to indicate whether or not CSMDPC agrees to the requested restrictions not guaranteed by law. I understand that CSMDPC may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me, including but not limited to voicemail messages, postcards or letters.

I understand that I have a number of rights below:

*The right to review and receive a copy of my medical record. CSMDPC is entitled to charge me a reasonable fee to the cost of copying my records. I also understand that according to New York

Law, CSMDPC may only copy medical records that they have created or test results from testing they have requested.

*The right to request the amendment (changing) of my medical record and if the Provider does not agree to my request, to note my objection in the medical record.

*The right to receive confidential communications of my health information and to direct the place and manner of communication.

*The right to grant or deny my record to other.

*The right to revoke, in writing, any consent that I provide for access to my record.

*The right to authorize Provider to give information about my care to relatives or close friends, to the extent of their involvement with my care or payment.

*The right to review an accounting list of disclosures of my medical records/information made by CSMDPC (Except for those disclosures that are made to me or with my specific authorization that fall within the scope of Provider's "health care operations," or disclosures made for payment or treatment purposes)

*The right to receive a paper copy of this notice and authorization.

I understand that if I believe that my privacy rights have been violated, I may complain to my Provider or to the Secretary of the U.S. Department of Health and Human Services.

You may also speak with our designated Privacy Complaints contact, Rebecca. CSMDPC will not retaliate in any way against a patient making a complaint.

CSMDPC may decide to change some of the above-stated policies, and I understand that I will be given a revised Notice if this occurs.

Please acknowledge receipt and review of this notice and authorization by signing below;

Signature for Patient or Patient's Representative: _____

Date: _____

Printed Name of Patient or Patient's Representative: _____

Relationship to Patient: _____

*****THIS SERVES AS A WRITTEN CONSENT PERMITTING THE BELOW-GIVEN PERSON TO DISCUSS MY MEDICAL INFORMATION WITH MY PHYSICIAN OR CSMDPC**

Name: _____ Relationship: _____

Date: _____