

Life Steps OB/GYN Health Care for Women, LLP

60 EAST END AVENUE, NEW YORK, NY 10028 PHONE: (212)860-4800 FAX: (212)860-4891

Patient Information

Patient Name: _____
(Last) (First)

Address: _____
(Street) (Apt) (City) (State) (Zip)

Date of Birth: _____ Employer: _____

S.S# _____ Occupation: _____

Home # _____ Marital Status: _____

Cell # _____

Work# _____

**What is your preferred mode of contact?

Email _____

Pharmacy# _____

How did you hear about us?

Spouse or Emergency Contact

Name: _____ Phone# _____

Address: _____
(Street) (City) (State) (Zip)

Primary Care Physician

Name: _____ Phone# _____

Address: _____
(Street) (City) (State) (Zip)

Primary Insurance Information

Company Name: _____ Phone# _____

Address: _____
(Street) (City) (State) (Zip)

Member ID _____ Group # _____

Policy Holder Name(Insured): _____ ()Spouse ()Significant ()
Parent/Guardian

Insured's Date of Birth _____ Insured's S.S# _____

Insured's Employer: _____

Insured's Occupation: _____

Secondary Insurance Information

Company Name: _____ Phone # _____

Address: _____
(Street) (City) (State) (Zip)

Name of Insured: _____ Relationship to Insured: _____

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Name: _____

Date: _____

Past Medical Problems:

Past Surgeries:

Medications: (including vitamins)

Allergies to Drugs and Reactions:

Family History:

Social History:

Smoker: YES/NO FREQUENCY _____

Alcohol: YES/NO FREQUENCY _____

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AGREEMENT TO RECEIVE MESSAGES CONTAINING (PHI) AT HOME
PERSONAL HEALTH INFORMATION

NAME: _____

PATIENT ID#: _____

I hereby authorize:

Dr. Morrone Dr. Kirsch Lifesteps Ob/Gyn

Or her designee to leave a message containing PHI necessary for my care.

*On my answering machine at home: _____

*At the following telephone number: _____

Signature of patient _____

Signature of personal representative _____

Print name _____

Date: _____

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Patient Insurance Portability and Accountability Act (HIPPA)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. reserve the right to revise its Notices of Private Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written or email request to Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. Privacy Office at 6 East End Ave, New York, N.Y. 1028 or lifestepsobgyn@gmail.com.

With this consent Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. may mail to my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care, including pathology and laboratory result among others.

With this consent Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, patient statements and material related to my clinical care so long as they are marked Personal and Confidential.

With this consent, Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. may send unencrypted email to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, patient statements and material pertaining to my clinical care including pathology and laboratory results among others. I have the right to request that Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to Lee Ellen Morrone, M.D. and Karen Kirsch, M.D. may decline to provide treatment for me.

Signature of Patient _____

Print Name _____

Date _____

Email address _____
(limited to administrative purposes and laboratory/pathology results)

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NOTICE OF PRIVACY PRACTICES

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, and billing or collection activities and utilization review. An example of this would be sending a bill or visit to your insurance company for payment.

HEALTH CARE OPERATIONS includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that writing request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

I have read and understand the above privacy policy.

Name: _____

Signature: _____

Date: _____