Alex J. Ky, M.D.

Patient Intake Form

First Name: _____ Last Name: _____

Sex: ☐ Male ☐ Female Age: _____ Date of birth: _____

Primary Care Physician: _____

Would you like a consult letter sent to your Primary Care Physician? ☐ YES ☐ NO

Referred by: _____

Chief complaint/Reason for visit: _____

_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who lives with you?_____

Do you smoke? ☐ YES ☐ NO If yes, how many packs/day? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks/day? _____

MEDICAL HISTORY

Please list any medications you are currently taking, including both prescription and over the counter:

_____

_____

_____

Please list any medical conditions or illnesses you have been diagnosed with:

_____

_____

_____

Please list any surgical operations or hospitalizations you have had:

_____

_____

_____

Please list any allergies and reactions you have:

_____

_____

Patient Name: _____

How many bowel movements do you generally have per day? _____

Do you experience pain with bowel movements? ☐ YES ☐ NO

Do you ever notice blood in your stool? ☐ YES ☐ NO

If yes, since when and how often? _____

Have you noticed any changes in your bowel habits? ☐ YES ☐ NO

If yes, please describe: _____

Have you ever had a colonoscopy? ☐ YES ☐ NO

If yes:

When was it done? _____

Whom was it done by? _____

What was the result? _____

Have any of your family members been diagnosed with colon or rectal cancer? ☐ YES ☐ NO

If yes, who? _____

REVIEWS OF SYSTEMS — Please fill out completely.			
Constitutional			
☐ No Symptoms	☐ Fatigue	☐ Fever	☐ Weight loss	☐ Other:
Cardiac			
☐ No Symptoms	☐ Chest Pain	☐ Palpitations	☐ Other:
Respiratory			
☐ No Symptoms	☐ Shortness of breath	☐ Wheezing	☐ Other:
Vascular			
☐ No Symptoms	☐ Leg cramps		☐ Other:
Gastrointestinal			
☐ No Symptoms	☐ Change in stool	☐ Constipation	☐ Other:
Genitourinary			
☐ No Symptoms	☐ Painful urination	☐ Blood in urine	☐ Other:
Eyes, Ears, Nose, Throat			
☐ No Symptoms	☐ Change in vision	☐ Pain swallowing	☐ Other:
Musculoskeletal			
☐ No Symptoms	☐ Joint pain	☐ Muscle spasm	☐ Other:
Psychiatric			
☐ No Symptoms	☐ Anxiety	☐ Depression	☐ Other:

Incontinence

	Never	**Rarely** (Less than once a month)	**Sometimes** (Less than once a week)	**Usually** (Less than once a day)	**Always** (Everyday)
Solid stool leakage	☐	☐	☐	☐	☐
Liquid stool leakage	☐	☐	☐	☐	☐
Gas leakage	☐	☐	☐	☐	☐
Pad use (for stool)	☐	☐	☐	☐	☐
Lifestyle restriction	☐	☐	☐	☐	☐

X _____ _____ ____/____/____

Signature Print Name Date

_____

Relationship to Patient (if not self)

Department of Surgery
Division of Colon and Rectal Surgery
Minimally Invasive Surgery

Alex J. Ky, M.D., F.A.C.S, F.A.S.C.R.S
Associate Professor of Surgery

5 East 98th Street, Box 1259
New York, NY 10029-6574

Practice Telephone: (212) 241-3547
Practice Fax: (212) 534-2654

Academic Telephone: (212) 241-7943
Academic Fax: (212) 534-2654

E-mail: colorectal@mountsinai.org

Date: _____

I, _____, am aware that during this initial consultation visit and future visits with Dr. Alex Ky, an examination will be performed. During the examination, I am aware that depending on what my reason for the visit and diagnosis is, certain procedures may be performed in the office during my visit.

<u>Possible procedures that may be performed in the office:</u>
Digital Examination
Anoscopy
Flexible Sigmoidoscopy
Hemorrhoid Banding
Incision and drainage
Excisions
Anal Pap Smears
Anal Manometry

_____
Signature

Mount Sinai Doctors *Faculty Practice*

Department of Surgery

Physician you are seeing: Alex J. Ky, M.D.	**Appointment date:**

PATIENT INFORMATION

Last name:	**First:**	**Middle Initial:**

How did you hear of us?

(Please check all that apply): [ ] Friend /Relative [ ] Employer/Coworker [ ] Brochure [ ] City MD [ ] Email [ ] ENT [ ] Facebook/twitter/Instagram

[ ]Google/Bing/Website [ ]Radio [ ]Health fair [ ] Insurance Co. [ ] Mount Sinai Website [ ]Newspaper [ ]Postcard

[ ]Subway/Bus/Kiosk Ad [ ] Television [ ] Walked By [ ] **Other**

PRIMARY CARE PROVIDER INFORMATION

Name:		
Address:	**City, State:**	**Zip:**
Phone: ( )	**Fax :** ( )	

IN CASE OF EMERGENCY

Please notify in case of emergency- Name:	**Relationship to Patient:**	
❑ Check if address is the same as the patient's		
Address:	**City, State:**	**Zip:**
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

NYS LAW, ALL PRESCRIPTIONS MUST BE SENT ELECTRONICALLY TO YOUR PHARMACY PLEASE PROVIDE THE PHARMACY'S CONTACT INFORMATION:

PHARMACY INFORMATION

Pharmacy Name:		
Address:	**City, State:**	**Zip:**
Phone: ( )	**Fax :** ( )	

Mount Sinai Doctors

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Mount Sinai Doctors Faculty Practice (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website, can be provided to me upon request, and may be posted in the office.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though they may be employed by, contracted by, or affiliated with Mount Sinai Health System hospitals or facilities. I understand that I can determine the health plans participated in by physicians who are employed by, are contracted by, or are affiliated with Mount Sinai Health System hospitals or facilities by visiting http://www.mountsinai.org/patient-care/find-a-doctor . I also understand that I can determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting those facilities' web portals at www.mountsinaihealth.org/insuranceinfo

I understand that laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services provided in connection with my care may not be billed by the Physicians, and may be billed separately by the laboratories/facilities/providers who provide those services (even if those services are provided by Mount Sinai Health System facilities, laboratories, or providers). I further understand that laboratories/facilities/providers who provide laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services may or may not be participating providers in my health care plan network, that I can obtain the contact information for any such laboratories/facilities/providers whose services may be needed in connection with my care from the Physicians, and that I can contact those laboratories/facilities/providers directly to obtain information regarding their health plan participation.

I understand that if I elect or choose to obtain services from a provider who I know or who has been disclosed (in writing, on a website, and/or at the time my appointment was made) as not participating in my health plan network, I will be responsible for any and all charges billed by that provider to me. I further understand that if the Physicians do not participate in or with my health plan and/or network, the amount or estimated amount that the Physicians will bill for healthcare services can be made available to me in advance, upon request.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card**.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient/Legal Representative Signature: _____

form version for eSignature

MOUNT SINAI HEALTH INFORMATION EXCHANGE (HIE) AND HEALTHIX CONSENT FORM

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants is updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of "The Mount Sinai Health System" (defined in MS HIE Fact Sheet) to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749**.** Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE. PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. I can also change my decision at any time by completing a new form. You have the following choices below. Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of** my electronic health information through the **Mount Sinai HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access** my electronic health information through the **Mount Sinai HIE** or and **I DENY CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ANY of** my electronic health information through **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by applicable law.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

_____	_____
Print Name of Patient	Patient Date of Birth
_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Mount Sinai HIE and Healthix
Fact Sheet

Details about patient information in the Mount Sinai HIE and Healthix and the consent process:

1. Definitions.

- "The Mount Sinai Health System" refers to Mount Sinai Doctors Faculty Practice, the Icahn School of Medicine at Mount Sinai, and the following 7 Member Hospitals:
    - Mount Sinai Beth Israel
    - Mount Sinai Beth Israel Brooklyn
    - The Mount Sinai Hospital
    - Mount Sinai Queens
    - Mount Sinai Roosevelt
    - Mount Sinai St. Luke's
    - New York Eye and Ear Infirmary of Mount Sinai

2. How Your Information Will be Used. Consistent with New York State and Federal law, your electronic health information may be used by the HIE and Healthix Participants to:

- Provide you with medical treatment and related services.
- Check whether you have health insurance and what it covers.
- Improve Payers and Insurers ability to meet quality and performance program requirements by having a more complete view of a patient's clinical information.
- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care (and related services) provided to you and all Mount Sinai patients and Healthix members and participating organizations.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

3. What Types of Information About You Are Included. If you give consent, the HIE Participants may access ALL of your electronic health information available through the Mount Sinai HIE and all employees, agents and members of the medical staff of Mount Sinai may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

4. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from Mount Sinai or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the Mount Sinai HIE website http://www.mountsinaiconnect.org. You can also contact the Mount Sinai HIE Privacy Officer by writing to: HIPAA Compliance Office, The Mount Sinai Medical Center, 1 Gustave L . Levy Place, Box 1016, New York, NY 10029 or calling: 212-241-4669. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.

5. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE or Healthix Participant and who are involved in your medical care; health care providers who are covering or on call for an approved HIE or Healthix Participant; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE or Healthix Participant who carry out activities permitted by this Consent Form as described above in paragraph one.

6. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

7. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you are concerned that someone who should not have seen or gotten access to information about you has done so via the Mount Sinai HIE, call one of the HIE Participants you have approved to access your records, visit the Mount Sinai HIE website: http://www.mountsinaiconnect.org, contact the Mount Sinai HIE Privacy Officer at the address and number above, call the NYS Department of Health at 877-690-2211, or contact the Federal Office of Civil Rights at www.hhs.gov/ocr/hipaa.gov. If your concern relates to access to your information via Healthix, call The Mount Sinai Health System at 212-241-4669; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

8. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE or Healthix Participant to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the Mount Sinai HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The Mount Sinai HIE, Healthix and persons, who access this information through these health information exchanges must comply with these requirements.

9. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time the Mount Sinai HIE ceases operation, or, with respect to Healthix, until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

10. **Changing Your Consent Status**. You can change your Consent Status at any time by signing a new Consent Form and selecting the "I DENY CONSENT" on page 1 of the form. You can get this Consent Form from your provider or on the Mount Sinai HIE website on the "Protecting Patient Health Information" page, http://www.mountsinai.org/ms-connect/protecting-patient-health-information. Once completed, please give the form to your provider and he or she will update our records appropriately.

    Note: Organizations, including Providers, that access your health information through the Mount Sinai HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return the information or remove it from their records.

11. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it if you so request**.**

MOUNT SINAI HEALTH SYSTEM

NOTICE OF PRIVACY PRACTICES

Patient Name:

Date of Birth:

MRN:

I am aware of Mount Sinai Health System's Notice of Privacy Practices and I understand that if I would like a copy of the booklet, I can pick one up at the front desk.

Date:

Patient Signature: