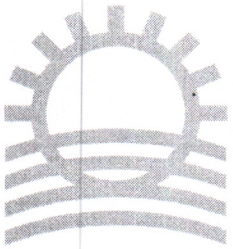


SUN MEDICAL CARE, P.C.

463 SARATOGA ROAD
SCOTIA, NY 12302
TELEPHONE (518) 399-2233
FAXCIMILE (518) 399-2951

WELCOME PACKET FOR HOME VISITS

1. Please review and complete the information requested in the following pages.

2. Front and back copy of your active health insurance card is needed.

3. Please read and sign the Health Information Patient Privacy (HIPPA) notice.

4. Sign the Record Release to obtain your medical records.

PATIENT INFORMATION

NAME:_____
(First) (Middle) (Last)

NAME OR NICKNAME TO ADDRESS YOU:_____

DATE OF BIRTH:_____ SEX: Male___ Female____

ADDRESS: _____
(Street) (City) (State) (ZIP)

EMAIL: _____

HOME PHONE (LAND LINE):_____

MOBILE PHONE :_____

MARITAL STATUS: SINGLE ___ MARRIED ___ DIVORCED _____ WIDOWED _____ COMMITTED _____

SPOUSE'S/PARTNER'S NAME: _____

EMERGENCY CONTACT #1: _____ RELATIONSHIP: _____

EMERGENCY CONTACT #1 PHONE NUMBER:_____

EMERGENCY CONTACT #2: _____RELATIONSHIP:_____

EMERGENCY CONTACT #2 PHONE NUMBER:_____

PHARMACY USED:

LOCAL:_____
(Name) (Address) (Phone and Fax numbers)

MAIL ORDER:_____
(Name) (Address) (Phone and Fax numbers)

FINANCIAL INFORMATION

DRIVER'S LICENSE NUMBER:_____

SOCIAL SECURITY NUMBER:_____

PRIMARY INSURANCE: _____

EFFECTIVE DATE: _____

POLICY HOLDER NAME:_____

INSURANCE IDENTIFICATION NUMBER:_____

GROUP NUMBER:_____

CUSTOMER SERVICE PHONE NUMBER: _____

IF YOUR INSURANCE REQUIRES A PRIMARY CARE TO BE REGISTERED WITH YOU, PLEASE CALL TO CHANGE YOUR PRIMARY TO DR. MINA SUN.

IF APPLICABLE:

SECONDARY INSURANCE: _____

EFFECTIVE DATE: _____

POLICY HOLDER NAME:_____

INSURANCE IDENTIFICATION NUMBER:_____

GROUP NUMBER:_____

CUSTOMER SERVICE PHONE NUMBER: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN FOR THE MEDICAL AND/OR SURGICAL BENEFIT. I AGREE TO FORWARD TO THE PHYSICIAN ANY PAYMENT THAT I MAY RECEIVE FROM MY INSURANCE COMPANY FOR THE SERVICE RENDERED. I AGREE TO PAY IN FULL ANY BALANCE FOR WHICH I AM RESPONSIBLE SUCH AS COPAYS, DEDUCTIBLES, COINSURANCE AND NON-COVERED EXPENSES. I WILL PAY FOR THE ENTIRE VISIT IF I FAIL TO PROVIDE CORRECT INSURANCE INFORMATION OR FAIL TO CHANGE THE PRIMARY CARE PHYSICIAN PRIOR TO RECEIVING MEDICAL SERVICE. I WILL PAY FOR THE SERVICE I RECEIVED IF MY INSURANCES FAILS TO PAY REGARDLESS OF THE ISSUES.

IF ANY PORTION OF MY ACCOUNT REMAINS UNPAID FOR 90 DAYS, THAT BALANCE SHALL BE SUBJECTED TO LATE FEE PENALTY AND ADDITIONAL INTEREST CHARGE OF 1.5% PER MONTH UNTIL PAID.

I AGREE THAT THE VENUE FOR ANY LEGAL ACTIONS INVOLVING COLLECTION OF UNPAID BALANCES SHALL BE GLENVILLE TOWN COURT, IN THE COUNTY OF SCHENECTADY, NEW YORK.

I AUTHORIZE SUN MEDICAL CARE, P.C. TO RELEASE ANY REQUIRED INFORMATION IN THE COURSE OF MEDICAL SERVICE TO MY HEALTH INSURANCE COMPANY FOR THE PUROSE OF PROCESSING MY CLAIM(S) FOR PAYMENT.

SIGNATURE PRINT NAME DATE

9/10/2020

SUN MEDICAL CARE , P. C. OFFICE POLICIES

OPERATIONAL

PRESCRIPTION REFILLS: Please give 5 business days for all refill requests, especially for the controlled medications.

PRIOR AUTHORIZATIONS FOR DIAGNOSTIC TESTS OR MEDICATIONS: Please allow 5 business days to process routine requests. Appeal process on denials will be up to the physician's discretion.

REFERRALS: Please allow 5 business days to process this by our staff. The staff will facilitate, but patient will need to follow up for appointment confirmation with the specialist.

AFTER HOUR SERVICE: This will be judged on a case –by-case basis. A surcharge of $30 may be applicable. Telehealth may be used to service you.

COUMADIN MONITORING: A low level office visit (99211) or a telephone visit will be charged.

FORM COMPLETION: $30 per page is charged, unless there is a visit (in person or teleheath).

MEDICAL RECORDS FEE: This practice may charge up to $0.75 per page.

NO SHOW FEE: $40 is charged for any appointment cancelled with less than 24 hour notice.

PHYSICIAN LETTER: $30 is charged for a physician letter for personal matters such as jury duty, travel, employment, legal, insurance payment, etc. Additional charge for time in increments of $30 per 15 minutes may apply for more complex letters.

RETURNED CHECK FEE: $30 returned check fee is added to all bounced checks. If not paid within 1 week, the bad check will be turned over to police department.

TELEPHONE SUPPORT: A telephone discussion is considered a telehealth visit. All calls more than 5 minutes with the physician or physician assistant will be charged.

Signature Print Date

SUN MEDICAL CARE , P. C. OFFICE POLICIES

FINANCIAL RESPONSIBILITIES

This office does not receive any government bailout. The physicians and staff are able to keep the doors open in order to service you only if the claims and statements are paid by your insurances and you, respectively.

COPAYS : This is collected prior to the service being rendered. Your visit will be rescheduled if you do not have your copay at the time of your appointment.

SELF PAY: This is collected prior to service being rendered. We do not bill.

LATE –FEE/FINANCE PENALTY: $15 is added for all unpaid balances after the 3rd patient statement.

DELINUQENT ACCOUNTS: These are sent to collection and your chart becomes inaccessible to provide service.

MEDICAID: This office is not a participating provider to Medicaid. If your insurance plan that administers your Medicaid benefit fails to pay, you are responsible for this balance. This policy applies to when your Medicaid is primary or secondary insurance.

DEDUCTIBLE AND COINSURANCE: If you have not met your deductible for the year at the time of your visit, the office will collect an estimated amount based on the service provided. The claim for your visit will be sent to your insurance for adjudication and the payment collected will be applied to the amount you are responsible. You may have a small balance or a credit.

If you have co-insurance, an estimated amount (about 20%) based on the service provided will need to be paid on the date of your visit.

****

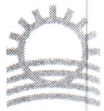
I understand that Sun Medical Care and the physicians do not participate with Medicaid. This means that I will be responsible for the Medicaid balances in insurance carriers that have Medicaid as part of the dual advantage plans with Medicaid and Medicare for every service I receive, regardless of the policies of the administering insurance carrier.

I agree to pay in full any balance that I am responsible such as copays, deductibles, coinsurance and non-covered expenses.

I will pay for the entire visit if I fail to provide the correct insurance information at the date of visit.

I will pay for the entire visit if I fail to change to the proper primary care physician at the date of visit.

Signature Print Date



Sun Medical Care

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Sun Medical Care to use and disclose protected information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Sun Medical Care's "Notice of Privacy Practices" provides a more complete description of such uses and disclosures.

With this consent the Sun Medical Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the department in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Sun Medical Care may mail to my home or other alternative location and discuss with person authorized below, any items that assist the practice in carrying out TPO.

_____ _____

Name of Person Relationship

With this consent, Sun Medical Care may e-mail my home or other alternative location any items that assist the practice in carrying out TPO.

By signing this form, I am consenting to the Sun Medical Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the department has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name (Print)

Telephone Number_____ E-mail Address_____

Sun Medical Care

NEW PATIENT MEDICAL HISTORY FORM

HOW WOULD YOU LIKE TO BE ADDRESSED BY OUR STAFF?

PLEASE LIST ALL OF YOUR PREVIOUS HOSPITALIZATIONS, OPERATIONS, BROKEN BONES. (WITH DATES)

1._____ 2._____

3._____ 4._____

5._____ 6._____

PLEASE LIST ALL MEDICAL CONDITIONS YOU HAVE WHICH REQUIRE DOCTOR'S VISITS, FOR EXAMPLE, THYROID DISEASE, HIGH BLOOD PRESSURE, DIABETES, HIGH CHOLESTEROL, ULCERS (WITH APPROXIMATE DATES OF ONSET).

1._____ 2._____

3._____ 4._____

5._____ 6._____

PLEASE LIST ALL MEDICATIONS YOU TAKE WITH DOSES. INCLUDE OVER-THE-COUNTER MEDICATIONS, VITAMINS, SUPPLIMENTS AND HERBAL REMEDIES TAKEN REGULARLY.

1._____ 2._____

3._____ 4._____

5._____ 6._____

You may use the back of the page if necessary.

Sun Medical Care

PLEASE LIST ALL ALLERGIES TO MEDICATIONS AND THE TYPE OF REACTION. INCLUDE ALLERGIES TO IODINE, SHELLFISH AND X-RAY DYES.

1._____2._____

3._____4._____

5._____6._____

DO YOU SMOKE? _____ HOW MANY CIGERETTES PER DAY? _____

HOW MANY YEARS HAVE YOU SMOKED? _____

HOW MUCH ALCOHOL DO YOU DRINK PER DAY? PLEASE BE SPECIFIC.

_____

WHAT DO YOU DO FOR A LIVING? _____

DESCRIBE YOUR SOCIAL SITUATION, I.E., MARRIED, SINGLE, DIVORCED, CHILDREN.

_____

PLEASE LIST YOUR IMMEDIATE FAMILY, THEIR AGES AND HEALTH PROBLEMS. WE ARE MOST INTERESTED IN PARENTS, BROTHERS AND SISTERS, CHILDREN. BE SURE TO MENTION PROBLEMS WITH HIGH BLOOD PRESSURE, DIABETES, THYROID DISEASE, CANCERS OR HEART DISEASE.

MOTHER_____ FATHER_____

SIBLINGS_____ CHILDREN_____

Sun Medical Care

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT YOU HAVE OR HAD IN THE PAST

___THYROID DISEASE
___HIGH BLOOD PRESSURE
___RHEUMATIC FEVER
___HEART MURMUR
___PALPITATIONS
___LIGHT HEADEDNESS
___LOSS OF CONSCIOUSNESS
___CHEST PAIN
___SHORTNESS OF BREATH
___SWELLING OF ANKLES
___ASTHMA
___RECURRING COUGH
___COUGHING UP BLOOD
___NAUSEA, VOMITING
___HEART BURN
___ACID REFLUX
___ULCERS
___ABDOMINAL PAIN
___HIATIAL HERNIA

WOMEN:

___PROBLEMS WITH MENSTRUAL PERIODS SUCH AS PAIN OR UNUSUAL BLEEDING
___PROBLEMS WITH YOUR BREASTS SUCH AS PAIN, LUMPS, DISCHARGE

___ANEMIA
___KIDNEY STONES
___BLADDER INFECTIONS
___SEXUALLY TRANSMITTED DISEASES
___HEADACHES
___SEIZURES
___WEIGHT GAIN OR LOSS
___CATARACTS
___GLAUCOMA
___MACULAR DEGENERATION
___URINATING MORE THAN 2 TIMES/NIGHT
___BURNING WITH URINATION
___ARTHRITIS
___BLOOD IN URINE
___DIABETES
___CHANGE IN BOWEL HABITS
___DIARRHEA
___CONSTIPATION
___BLOOD IN STOOL

MEN:

___DIFFICULY STARTING STREAM (NEED TO WAIT OR STRAIN)
___THIN STREAM OF URINE

Sun Medical Care PC Permission/Consent for Telehealth Visits for Home Bound Patients

Telehealth for Home Bound Patients: Sun Medical Care is currently unable to service urgent or emergent house calls requests. Telehealth may be used as a substitute.

What is telehealth?

Telehealth is away to visit with healthcare providers, such as your doctor, physician assistant, or nurse practitioner. You can talk to your provider from any place, including your home. You do not go to a clinic or hospital.

How do I use telehealth?

You talk to your provider by phone, computer, or tablet. Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- **You do not have to go to a clinic or hospital to see** your provider.
- You would not risk getting sick from other people.
- The provider has more flexibility to service you, especially on the weekends.

Can telehealth be bad for me?

- You and your provider would not be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We do not know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will wear head sets to minimize someone else from hearing you. The office staff may be able to see you during the encounter.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I want an office visit, not a telehealth visit?

You may request for a in person office visit. However, if you have a contagious infection, the provider has the right to screen and use telehealth for evaluation.

What if I try telehealth and do not like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
  - Call **(518)399-2233** and say you want to stop, **OR**
  - sign into your patient portal and note your preference

  It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

  Same copay, deductible, or coinsurance may be applicable. How your telehealth is adjudicated is per your insurance policy. The provider has not say in this matter.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print) Date

Your signature Date

9/10/2020

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:
Sun Medical Care, P. C. 463 Saratoga Road, Scotia, NY 12302

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: _____

_____

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.**