

SUN MEDICAL CARE, P.C.

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

## WELCOME PACKET

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.

## COVID PRECAUTIONS

Due to the current pandemic, please note the following

- Call the office if you do not feel well. Do not just drop in.
- Telehealth may be utilized for triage or evaluation.
- Mask is mandatory.
- Only one party will be allowed in the waiting room.

Our provider is tested weekly to ascertain COVID negative status.

**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 : \_\_\_\_\_

WORK NAME AND ADDRESS: \_\_\_\_\_

WORK 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 SUND MEDICAL CARE, P.C. TO RELEASE ANY REQUIRED INFORMATION IN THE COURSE OF MEDICAL SERVICE TO MY HEALTH INSURANCE COMPANY FOR THE PUPOSE OF PROCESSING MY CLAIM(S) FOR PAYMENT.

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SIGNATURE

PRINT NAME

DATE

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 telehealth).

**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.

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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 3<sup>rd</sup> patient statement.

**DELINQUENT 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.

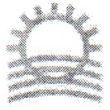
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Signature

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

\_\_\_\_\_  
Name of Person

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
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 PC Permission/Consent** **for Telehealth Visits**

### **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 no say in this matter.

**Do I have to sign this document?**

Yes, if you want to have a visit. Due to the Covid19 environment at this time, it is possible that the only type of visit possible may be via 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.
- You understand that your insurance will be billed for a telehealth visit.

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

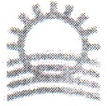
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Your name (please print) Date

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Your signature Date





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 CIGARETTES 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
- HIATAL 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:**

- DIFFICULTY STARTING STREAM (NEED TO WAIT OR STRAIN)
- THIN STREAM OF URINE



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.



**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 (P) 518-399-2233 (F) 518-399-2951**

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 \_\_\_\_\_ I authorize \_\_\_\_\_  
 \_\_\_\_\_  
 Initials 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: <input type="checkbox"/> At request of individual <input type="checkbox"/> 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.**