Karen R Banks-Lindner, DO, PLLC
Michele Provost, MPAS, RPA-C
45-47 Hale Street
Norwich, NY 13815
Phone: 607-336-1749 Fax: 607-334-3700

"The Way Medicine Was Meant To Be"

Dear Patient:

Welcome to the Internal Medicine practice of Dr. Karen Banks-Lindner, DO PLLC and Michele Provost, MPAS, RPA-C. We would like to take the opportunity to explain some of our office police and procedures so you will have a better understanding of how this office functions. This will help us to practice medicine in an efficient manner and provide you with the highest quality of care possible.

Office Appointments: This office functions on the basis of scheduled appointments. If you are ill, our staff will make every effort to provide you with an appointment within 24 hours. Please call to see if we have an appointment available prior to going to the walk in center.

Appointment cancellation and Rescheduling: We are aware that situations arise that may require you to miss a scheduled appointment. If you are unable to keep a scheduled appointment, we ask that you please call our office 24 hours prior to your appointment to cancel or reschedule.

No Shows or Missed Appointments: In the event that a patient misses (3) or more scheduled appointments without notifying our office 24 hours prior to the appointment time, we will retain the right to discharge that patient from our practice. The courtesy of your prompt notice of the need to cancel or reschedule an appointment will allow us to refill your appointment slot with another patient in need. If you should not show for an appointment without giving us advanced notice of cancelation you will incur a $25.00 no show fee. This fee is a personal fee and will **NOT** be billed to your insurance. You will be responsible to pay the fee. This fee must be paid prior to your next visit. If you are more than 15 minutes late for scheduled appointment it will be considered a missed appointment and will be charged the no show fee.

Prescriptions: Our Staff will be happy to call in your prescriptions. In order to insure their accuracy you will need to provide us with name of drug, dosage, directions, quantity and where you would like them called in. We will make every attempt to do so within 24 hours. If you are completely out of medicine at the time of your call please notify us of the fact so we can call it in immediately. No narcotics (controlled substance) can be called in so you will need to pick up those prescriptions during regular office hours. If you are on chronic narcotics / controlled substance we reserve the right to drug test you at any time. Please let us know at the time of your visit if you require any prescription refills. Some drugs require prior authorization. This process can take up to 7 days to receive a response from the insurance companies. We have no control on how long it takes them to approve or deny a drug. All prescriptions for controlled substances should be picked up by you personally unless other arrangements have been made.

Billing: It is your responsibility to notify us of any changes in your insurance, your phone number or your address. All payment is expected at the time of your office visit. Payment includes any co-payments or deductibles due. We will bill your insurance for you and then bill you for the reaming portion. If your bill becomes delinquent it will be sent to collection. If we are forced to send your bill to collection you will incur an additional $15.00 fee to cover the cost of collections. To avoid collections please submit payment upon receipt of your statement. If you are unable to pay your bill in full please call our office to set up a payment arrangement. If you bounce a check you will incur a $25.00 bounced check fee. This fee is payable to us prior to your next office visit.

____

Patient Signature

Form Fee: All Forms should ideally be filled out at an office visit (i.e. disability, DMV, FMLA, ETC.). If you are unable to come in for a visit to fill out any form there will be a $5.00 per page fee for the form to be filled out. You will need to pay the fee at the time you drop off the form. Forms will not be filled out until payment has been received. This fee will NOT be billed to your insurance but must be paid by you personally. If you have not been seen within 30 days, per New York Stale law, you must have an appointment before we will fill out any form.

Test Results: Our office staff will notify you of all test results that we have ordered. If the test was ordered by a different provider you must obtain your results from the ordering provider. If you have not heard from us within ten (10) days please call our office so we can obtain your results if we have not received them.

Insurance Cards: Insurance cards will be verified at each and every visit to insure there have been no changes. Please be sure to bring your card with you to each visit. If you have a separate insurance benefit card for prescriptions please bring that with you as well and we will make a copy for your chart.

Referrals: Some insurance companies require referrals. It is your responsibility to know if you require one to see a specialist or another provider. We will be happy to do one if we have seen you for the problem in the past 30 days. If we have not seen you for the same problem you will need an appointment with us first. This is to insure you are planning on seeing the appropriate specialist. We will schedule one appointment for you with your specialist if you need to change it for any reason it will be your responsibility to do so.

We Hope this information is helpful to you. Once again, we would like to welcome you and thank you for the opportunity to provide you with your medical care "The way it was meant to be". If you have any Questions about the above information please do not hesitate to ask us and we will be happy to provide you with an answer.

Sincerely,

Dr. Karen Banks-Lindner, DO, PLLC
Michele Provost. MPAS, RPA-C

Your signature below indicates that you have read and understand this letter and you agree to the above terms. I hereby authorize Dr. Karen R. Banks-Lindner and Karen R Banks-Lindner DO-PLLC to furnish information to insurance carriers concerning illness and treatments and I herby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

______________________________ ____________________
Patient Signature Date

____
Print Patient Signature

Southern Tier HealthLink NY (STHL) Health Information Exchange
RHIO CONSENT FORM

PROVIDER: Karen R. Banks-Lindner DO PLLC

In this Consent Form, you can choose whether to allow the provider named above to obtain access to your medical records through a computer network operated by Southern Tier HealthLink (STHL), the Regional Health Information Organization (RHIO) of the Southern Tier of New York. STHL is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow the provider named above to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, the above named provider's staff involved in my care may see and get access to all of my medical records through Southern Tier HealthLink.

If you check the **"I DENY CONSENT"** box below, you are saying "No, the above named provider may not be given access to my medical records through Southern Tier HealthLink for any purpose."

If you check the **"I CHOOSE NOT TO CONSENT or CANNOT DECIDE AT THIS TIME"** box, you are saying, "No, the above named provider may not be given access to my medical records through STHL EXCEPT in a medical emergency."

Southern Tier HealthLink is a not-for-profit organization. It shares 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 ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your provider for it, or go to the website www.ehealth4ny.org.

You can manage your consent options online for all participating providers and review who has accessed your information using the Southern Tier HealthLink Patient Portal (www.sthlny.com). By providing an email address below you will be automatically enrolled. You will be contacted by Southern Tier HealthLink with your username and password.

Please carefully read the STHL Information Sheet before making your decision. You have three choices.

☐ **I GIVE CONSENT for the Provider named above to access ALL** of my electronic health information through Southern Tier HealthLink in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT for the Provider named above to access** my electronic health information through Southern Tier HealthLink for any purpose, *even in a medical emergency.*

☐ **I CHOOSE NOT TO CONSENT or CANNOT DECIDE AT THIS TIME.** The Provider named above will have access to my information ***ONLY in a medical emergency.***

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

Karen R. Banks-Lindner, DO, PLLC

PO Box 1017, Norwich, NY 13815
607.336.1749

CONSENT TO TREATMENT / USE OF PROTECTED HEALTH INFORMATION

I, ____ am presenting myself for care at Karen R. Banks-Lindner, DO, PLLC and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of Karen R. Banks-Lindner, DO, PLLC or their designees, as may in their professional judgment be deemed necessary or beneficial.

I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition.

CONSENT TO USE PROTECTED HEALTH INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of the notice may change. If we change our notice you may obtain a revised copy by referring to the Karen R. Banks-Lindner, DO, PLLC Privacy Notice.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations as well as acknowledge the receipt of the Karen R. Banks-Lindner, DO, PLLC Privacy Notices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your consent.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and transfer to Karen R. Banks-Lindner, DO, PLLC and each and all of its affiliates sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs for the care and treatment rendered to myself or my dependant.

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under title XVII 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 Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

BENEFIT QUOTES

Insurance benefits quoted to Karen R. Banks-Lindner, DO, PLLC and each and all of its affiliate providers are not a guarantee of payment. Patients are ultimately responsible to confirm benefits with their own insurance company.

MARKET RESEARCH

I authorize Karen R. Banks-Lindner, DO, PLLC or representatives on its behalf, to contact me for patient feedback about the services it has provided to me. I understand that my name could be picked for feedback on my specific medical condition when Karen R. Banks-Lindner, DO, PLLC is seeking to improve the health care of patients with certain conditions. I also understand that this may involve Karen R. Banks-Lindner, DO, PLLC disclosing my name and medical condition to an outside company that is contracted to collect the feedback for Karen R. Banks-Lindner, DO, PLLC. Any such company would be required to keep my name and condition confidential.

______________________________	______________________________	__________
Witness	Patient Signature	Date

*Because the patient is an unemancipated minor ________ years of age or, is unable to sign for the following reason:

____

The above consent is given on the patient's behalf by:

______________________________	______________________________	__________
Witness	Parent/Legal Guardian or Health Care Agent	Date

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Phone: 607-336-1749 Fax: 607-334-3700

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REGISTRATION/INSURANCE INFORMATION

PATIENT INFORMATION:

Name: ______________________________

Address: ______________________________

City/State/Zip Code: ______________________________

Phone #'s: (Home) ______________ (Work) ______________ (Cell) ______________

Date of Birth: __________ SS#: ______________ Employer: ______________________

Occupation: ______________________

Email address: ______________________________

May we contact you by e-mail: YES / NO

Emergency Contact: ______________________ Relationship to patient: __________

Phone #: (Best way to contact them in an emergency, indicate H/W/C): (   ) ______________

Emergency Contact: ______________________ Relationship to patient: __________

Phone #: (Best way to contact them in an emergency, indicate H/W/C): (   ) ______________

INSURED INFORMATION: (person who holds insurance)

I (the undersigned) am covered by insurance issued by ______________ (primary insurance name) ______________ (secondary insurance, if any). I am requesting treatment from Karen R. Banks-Lindner DO, PLLC. My primary care physician is ______________________.

I understand it is my responsibility:

a. to provide proof of current active insurance. We will copy your insurance card into our EMR

b. to be aware if and when my current insurance covers preventative care and/or blood work associated with well care and to provide name of Laboratory my current insurance participates with

c. to change my PCP, if needed, by directly contacting my insurance Member Service, making the change effective today.

d. to request a referral from my PCP prior to any specialist visit (referrals can not be back-dated). It is the responsibility of the **PATIENT** to know if a referral is needed.

e. to obtain authorization from my insurance if our office is NON-PAR (non-participant) with my insurance.

f. to bring request from referring physician for PRE-OP Clearance. Not all insurances PAY for pre-op, blood work or EKG provided by primary doctor, even if referring doctor makes request.

In addition to the above,

g. I agree to give at least 24 hours' notice if unable to attend a scheduled appointment. Failure to do so will cause a fee of $25.00 which is **NOT** billable to insurance. If you are more than 15 minutes late it will be considered a missed appointment

h. if checks are returned due to insufficient funds a fee will be assessed.

i. In the event a claim for service is denied by the insurance carrier on record in chart **I am agreeing that I shall be responsible for payment in full** for charges related to office visits, including blood work and other testing. Correct insurance information is necessary to submit insurance claims within the 90 day filing limit.

SIGNED: ______________________ DATE: ______________

(Patient or responsible party for patient)

Karen R Banks-Lindner DO, PLLC
Effective 12/18/10

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE - You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION - "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; and (4) post and make available to you any revised Notice. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION - Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures - By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment - We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations - We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment. For example, we will contact you at your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address. We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practices. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our Practice and our services.

Required by Law - We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health - We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products.

Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.

Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review.

Legal Proceedings - We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement - We may disclose protected health information for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations - We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

Research - We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety - Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation - We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

Inmates - We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access - State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION - In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care - Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION - You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy - You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions - You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment and pertains solely to a health care item or service for which we have been paid out of pocket in full. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications - You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment - If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure - You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record – If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Right to Obtain a Copy of this Notice - You may obtain a paper copy of this Notice from us by requesting one **[If applicable:** or view it or down load it electronically at our Practice's website at .]

Special Protections - This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, mental health information, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice.

Complaints - If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION - Our Privacy Officer is Richard Lindner and can be contacted at this office or by calling our telephone number. 607-336-1749. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices. **[If applicable:** You may also email questions to our Privacy Officer at the following email address:]

Revised 12/18/10