Karen R Banks-Lindner, DO, PLLC
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. We would like to take the opportunity to explain some of our office policies 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 a walk in center. You may also use our patient portal to obtain an appointment 24 hours a day.

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 are more than 15 minutes late for your scheduled appointment it will be considered a missed appointment.

Prescriptions: Our Staff will be happy to send 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 on chronic narcotics / controlled substance we reserve the right to drug test and or preform a pill count. If called for a pill count you will have 24 hours to present with all your medications to the office. If you do not do so we have the option to discharge you from the practice. 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

Billing: It is your responsibility to notify us of any changes in your insurance, phone number, address or any other contact information. We will retain the right to **discharge** that patient from the practice of Dr. Karen R. Banks-Lindner DO PLLC if your information is **NOT** kept current. All payments are 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 remaining 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 $5.00 fee for the 3rd invoice sent and a 5.00 collection fee for the 4th invoice sent to cover the cost of collections. Karen R Bank-Lindner also reserves the right to discharge you from the practice for any bill that is more than 120 days old. To avoid collections fees or possible termination from the practice of Karen R Banks-Lindner 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. We understand times are tough and we are more than willing to work with you in any way we can. If you bounce a check you will incur a $30.00 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. We ask you to notify us of any tests or changes by other providers so we may obtain copies and or update your chart. 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. It is your responsibility to return messages in a timely fashion left for me either by phone, mail or patient portal if not I could be discharged from the practice of Dr. Karen R Banks-Lindner DO PLLC.

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.

Recommended testing and specialty care: Quality care has always been important to everyone at the practice of Dr. Karen R. Banks-Lindner DO PLLC from the front staff to the providers. Our goal is to help you be as healthy as possible. So at times that might require us to ask you to have specific testing done. Which could include but not limited to the following Pap Smear/GYN Exam, Diabetic eye exam, Urinalysis, Fecal occult cards/colonoscopy, Lab tests, Stress test, Mammogram/Breast Ultrasound, Prostate Exam/PSA ETC. For the same reason we might ask you to go to a specialist for follow up care. As a patient you have the right to refuse. However the practice of Dr. Karen R. Banks-Lindner DO PLLC and its providers will retain the right to discharge any patient from the practice that it sees fit. We will also ask you to sign a letter of refusal. Some insurance companies insist that we contact you for these tests and we will require you to come in and discuss the option available. We would like to remind all of our patients that we are a completely independent private practice with **NO** financial ties to any medical organization. We also believe that preventive medicine and patient interaction is the key to a longer healthier life.

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

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 or refusal for treatment and I hereby 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

HealthlinkNY Health Information Exchange
LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: Karen R Banks-Linder DO PLLC

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I receive health care. HealthlinkNY is a not-for-profit organization that electronically shares information about people's health and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to receive medical care or obtain health insurance coverage. Your choice to give or deny consent may not be used as the basis for denial of health services. The choice you make on 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.

Before making your decision, please carefully read the Consent Form Information Sheet about how your information is used.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form. This form must be filled out completely to be valid.

Please choose only one of the following two options:

☐ **I GIVE CONSENT** for the Provider Organization or Health Plan named above to access ALL of my electronic health information through HealthlinkNY in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050.

Printed First Name of Patient	Printed Last Name of Patient	Patient Date of Birth (MM / DD / YYYY)

Signature of Patient	Date of Signature (MM / DD / YYYY)

This section below is to be completed by the Patient's Legal Representative (if applicable)

Printed First Name of Legal Representative	Printed Last Name of Legal Representative	Relationship of Legal Representative

Legal Representative Signature	Date of Legal Representative Signature (MM / DD / YYYY)

HealthlinkNY
Health Information Exchange

CONSENT FORM INFORMATION SHEET

Details about patient information in HealthlinkNY and the consent process

1. How will your information be used? Your electronic health information will be used only for the following healthcare services:

- **Treatment Services.** Provide you with medical treatment and related services.
- **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
- **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of 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.
- **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. What types of information will be available? If you give consent, the Provider Organization or Health Plan named on the form may access ALL of your electronic health information available through HealthlinkNY. 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
- HIV/AIDS
- Mental health conditions
- Genetic (inherited) diseases or tests
- Sexually transmitted diseases
- Birth control and abortion (family planning)

If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. Where does your health information come 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 list of current information sources is available on the HealthlinkNY website at www.healthlinkny.com or by calling 844-840-0050.

4. Who may access your information if you give consent? Only authorized providers, other staff members, and affiliated practitioners of the Provider Organization or Health Plan named on the form who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Public Health and Organ Procurement Organization Access. Because 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 HealthlinkNY for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. Are there 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 you suspect that your records have been accessed by someone not authorized to do so, contact HealthlinkNY for an access audit at info@healthlinkny.com or 844-840-0050; or if you prefer to contact your Provider Organization or Health Plan directly, you can access their contact information on the HealthlinkNY website at: www.healthlinkny.com/participating-providers-pg.html; or the NYS Department of Health at 518-474-4987; or follow the complaint process at the following HHS Office for Civil Rights link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

CONSENT FORM INFORMATION SHEET

7. Is re-disclosure of my information permitted? Any electronic health information about you may be re-disclosed by the Participating Organization or Health Plan named on the form 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 paper form. Some state and federal laws provide special protections for certain kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment, and special requirements must be followed whenever this kind of sensitive health information is disclosed. The Participating Organization or Health Plan named on the form and persons who access this information through HealthlinkNY must comply with these requirements.

8. How long will your consent be in effect? This Consent Form will remain in effect until the day you change your consent choice or until such time HealthlinkNY ceases operation ***(or until 50 years after your death whichever occurs first)***. If HealthlinkNY merges with another Qualified Entity your consent choices will remain in effect with the newly merged entity.

9. How do you update or withdraw your consent? You can change your consent choice at any time for any Participating Organization or Health Plan by submitting a new Consent Form with your new choice.

Note: Organizations that access your health information through HealthlinkNY, while your consent is in effect, may copy or include your information in their own medical records. Even if you later decide to change your consent, they are not required to return it or remove it from their records.

10. You are entitled to receive a copy of this Consent Form after you sign it.

THIS FORM MEETS ALL REQUIREMENTS OF THE FEDERAL CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS (42 C.F.R. PART 2), THE NEW YORK STATE DEPARTMENT OF HEALTH PUBLIC HEALTH LAW 18 AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) (45 C.F.R PARTS 160 AND 164).

Karen R Banks-Lindner, DO, PLLC
45-47 Hale Street
Norwich, NY 13815

CONSENT TO TREATMENT / USE OF PROTECTED HEALTH INFPRMATION

1._____ 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 judgement be deemed necessary or beneficial.

I acknowledge that no guarantees have been made as to the effect of such examinations 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 this notice may change, if we change our notice you may obtain a revised copy by referring to the Karen R Banks-Lindner DO, PLLC.

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 these restrictions, 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 you consent,

ASSIGNMENT OF INSURANCE BENIFITS

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 other who are financially liable for my hospitalizations and medical care to cover the costs for the care of treatment rendered to myself or my dependent.

FOR PATIENT 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 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.

BENIFITS 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 provider for 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.

_____ _____ _____

Patient signature Witness date

(Because the patient is minor ____years of age or, is unable to sign for the following reason:

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

_____ _____ _____

Parent/legal guardian or health care agent witness date

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

"The Way Medicine Was Meant To Be"

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 cannot 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. 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 $30.00 fee will be assessed.
i. It is my reasonability to return messages in a timely fashion if not I could be discharged from Dr. Karen R Banks-Lindner DO PLLC
j. 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 01/11/2022

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

KAREN R. BANKS-LINDNER, D.O, PLLC
45-47 HALE ST
NORWICH, N.Y. 13815-2038
Phone: 607-336-1749 Fax: 607-334-3700

FINANCIAL POLICY

Medicare/PPO/HMO/Managed Care: You are responsible for remitting co-pays at the time of service and unless otherwise indicated, responsible for obtaining the necessary referrals/authorizations your plan requires. If you fail to do so, you will be responsible for payment. These are policy provisions which you agreed to adhere to when you signed up for the plan. We will submit all charges and follow-up with your carrier for payment. You are responsible for all deductibles, co-pays and any other non-covered charges.

No-Fault/Workers Compensation: You are responsible for providing our office with the necessary information needed to properly submit charges. If you fail to do so, the fees mandated by NY State will be changed to reflect our private fees and you will be responsible for payment. Some No-fault carriers have deductibles on medical charges, for which the patient (not the insured) is responsible. If you have private insurance we will submit on your behalf and bill you for any unpaid balances.

Medicaid: You are responsible for providing our office with your ID# (begins with 2 alpha letters, followed by numerical digits & ending with 1 alpha letter). If you have a managed medicaid plan (Fidelis Care, Total Care, etc) you are responsible for obtaining a referral from your Primary Care Physician; otherwise payment will not be made. If you fail to do so, you will be responsible for payment.

Non-participating Carriers: You are ultimately responsible for all charges if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary information needed to properly bill, we will submit on your behalf. You are responsible for following-up with your insurance carrier for unpaid claims and/or appeals. You are responsible for all deductibles, co-pays, and non-covered charges.

Liability: Carriers usually remit payment to the patient or the patient's attorney if one has been retained. OUR POLICY DOES NOT ALLOW US TO HOLD ACCOUNTS WHICH ARE PENDING RESOLUTION OF ANY LIABILITY OR LITIGATION ISSUES. WE DO NOT, UNDER ANY CIRCUMSTANCE, BILL ATTORNEYS. If you provide a letter from the liability carrier indicating they accept full responsibility and will remit payment, we will submit on your behalf. Otherwise, you may either have charges submitted to your private carrier or pay for services and obtain reimbursement upon resolution/settlement.

Self-pay: If you are uninsured, you are responsible for remitting payment in full at the time of service, unless prior arrangements have been made with the Billing Dept. If you are unable to remit payment in full and need to discuss payment options available to you, you must contact our Billing Department at: , Monday-Friday, 8:30am-4:00pm.If you need further explanation of any of the above policies, please contact the Billing Department directly. Thank you for your cooperation in this matter.

Patient Signature_____ **Date:**_____

I have read and/or been advised to read the entire Financial Policy.

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare Benefits be made on my behalf to provider for any services rendered to me by the physician. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature:_____ **Date:**_____

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Norwich, NY 13815
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"The Way Medicine Was Meant To Be"

HIPAA Contact Release Form

Dear patient,

In order to help us stay within the guidelines of **HIPPA**, please list below any person/persons that you authorize us to discuss information regarding your Protected Health Information, Including billing information. **(You do not need to list any of your doctors.)**

	Name	**Relationship**	**Phone**
1.	_____	_____	_____Home, Cell
2.	_____	_____	_____Home, Cell
3.	_____	_____	_____Home, Cell
4.	_____	_____	_____Home, Cell

Do we have permission to leave information on your answering machine when you are not at home?

YES_____ **NO**_____

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's (or Guardian's) Signature Date

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45-47 Hale Street
Norwich, NY 13815
Phone: 607-336-1749 Fax: 607-334-3700

"The Way Medicine Was Meant To Be"

INFORMED CONSENT FOR THE PRESCRIPTION OF PAIN MEDS AND CONTROLLED SUBSTANCES AND PATIENT PRACTICE MANAGEMENT

Part of your treatment program may involve the prescription of pain relieving medications or controlled substances. These medications have both beneficial effects, as well as side effects, which act on the nervous system (brain and nerves). Pain medications often produce very substantial relief of even the most severe pain and can improve a patient's quality of life and ability to function normally. This is certainly the most important goal for you. Side effects are usually mild and very manageable, but may include sedation, fatigue, euphoria, stimulation, confusion, poor judgment, and lack of coordination. Other side effects involve the stomach and intestines and may include nausea or vomiting, diarrhea, constipation, dry mouth and changes in appetite. In rare cases, difficulty breathing, bleeding from the stomach or severe allergic reactions may occur. In nearly all cases, a medical program can be developed in which the benefits of the pain medications far outweigh the risk of complication or serious side effects.

Although the majority of patients control their medications well and follow their doctors' orders very strictly, there are some patients that are prone to harmful medication dependency or addiction. Because of this, the state and federal government carefully regulate these medications. This means that the use of these medications involve special responsibilities on the part of both patient and provider (physician). This is especially true when opiod medications (narcotics as codeine, morphine, hydrocodone, oxycodone, etc) are prescribed. It is very important that you read and understand the following policies and procedures. They must be followed for your provider to prescribe pain medications safely and effectively.

1. It is vital to adhere to your providers orders on how to take your pain medication. Never take more than the prescribed dose without first consulting your provider. Do not abruptly decrease or stop your pain or anxiety medication as you may experience "withdrawal" symptoms. Symptoms may include anxiety, insomnia, abdominal pain or may be more serious such as convulsions, seizures, or heart problems. _____
2. If your provider agrees to prescribe medications for you, then no other physicians should prescribe any pain reliever or sedative medication without the written permission and knowledge of your provider. No emergency room visits expressly for the purpose of receiving pain medications including injectable pain medications. _____
3. It is essential that all prescriptions for pain medication be obtained from your physician at the time of an office visit scheduled by appointment at least 3-5 days before you may run out of your medication. We will not prescribe new pain medications over the phone nor will we adjust your dosage over the phone. We must see you and document in your chart the reasons for the change of your medications._____
4. Our practice is very busy caring for patients with all variety of medical issues. Our schedule is often quite full. Therefore, it is essential to plan in advance when scheduling your follow-up appointments. If you run out of medication due to poor planning or due to taking medication incorrectly, you are responsible for the consequences, including poor pain control or any withdrawal symptoms. Most of our patients on pain medications will be seen monthly and closely monitored._____
5. Out of respect for all patients seen in our practice, as well as the physician's time commitment patients will automatically be terminated from the practice following the failure of the patient to be seen for two appointments. _____
6. Lost, stolen or misplaced prescriptions or medications will not be replaced. Early requests for refills will not be honored. Selling medication or sharing medication with family, friends or any other person is illegal and will not be tolerated. You should protect and care for your medication as you would any extremely valuable possession. Care should be taken to prevent inadvertent consumption of your medication by any other person, as this could be very dangerous. _____
7. Many insurance policies restrict the type and quantity of medications prescribed. We will make an effort to work within these restrictions, but it is ultimately your responsibility to obtain your medication as prescribed. Patient complaints filed

with the customer service section of your insurance company or complaints to your pharmacist are often very effective at resolving difficult problems. _____

8. It is very important to understand that all pain relieving medications and many medications for anxiety have the potential to cause drowsiness, poor judgment, lack of coordination and other sedative effects. Therefore, it is your responsibility to exercise the greatest possible caution when attempting to operate a motor vehicle, driving equipment, or any machinery operation. In fact we advise not to engage in these activities while on your medications. Signing important documents or making other decisions should only be done when your thinking processes are completely clear. Alcohol, other recreational drugs, and some over the counter medications may intensify the effects of pain medications and should be avoided unless specifically discussed with your provider. It is important to maintain the best possible general health during pain treatment so that the benefits of pain medication can be optimized. _____
9. All prescription drugs in the United States have a label approved by the USFDA. This label provides an indication and dosage for the drug, but neither physician nor patient is legally bound to follow them. Pain treatment is virtually impossible unless the physician is allowed the flexibility to prescribe one or more medication that are for an indication or dosage not listed on the drug label (off-label usage). _____
10. Any and all off-label use of drugs are covered by this consent including, but not limited to the following:
    a. "oral transmucosal formulations" (medications absorbed through the lining of the mouth) for non-cancer pain
    b. The use of antidepressants, anti-epileptics, muscle relaxants, tranquilizers, and nutriceuticals for pain relief.
    c. Medications titrated to effective treatment levels.
    d. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary, published maximal dosing level.
    e. Topical use of prescribed mixtures of medications.

We expect you to take the above patient responsibilities very seriously. Failure to comply with our policies may result in immediate dismissal from our practice or termination of all or part of your medical regimen, regardless of any withdrawal effects, poor pain control, or other consequences.

I authorize my doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations. _____

I agree that I will submit to a urine, blood or hair follicle test as requested by my doctor to determine my compliance with my program of pain control medicines at my own expense. I agree to bring in my medications for random pill counts. I will have 24 hours from the time of contact to bring in my medications to be counted or else I may be terminated from the office. _____

I understand that this medication regime will be continued for a period of three months. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regime will be tapered to my pre-trial medication. _____

I acknowledge that pain control cannot be achieved without "off-label" use of one or more drugs. The undersigned furthermore accepts all risks and complications that may occur from off-label use, since the benefit of pain control cannot otherwise be achieved. The undersigned agrees to waive all liability against the physicians and the office which provides said medications. _____

I agree to use the following pharmacy for filling all of my medications. _____

I have read and understand all of the above policies and all of my questions have been answered. This agreement applies to medications written by our physicians only. I agree to comply with all of the conditions for prescription of pain medication as set forth by my doctor. I understand that failure to comply may result in my immediate dismissal from my doctor's care.

This agreement is entered into on _____

Patient signature_____ Witness Signature _____

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:
Karen R Banks-Lindner DO, PLLC 45 Hale St, Norwich, NY, 13815 PH# 607-336-1749 / Fax# 607-334-3700

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: ❑ 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.**