Arthritis Health Associates

Mary Abdulky, **MD**
George Mtanos, **MD**
James Hyla, **MD**
Ramzi Khairallah, **MD**
Maria Pasniciuc, **MD**

Lynne McIlvain, **PA**
Heather Machovec, **PA**
Sheri Spink-Palmieri, **PA**
Jennifer L Lafrance, **NP**
Kathleen Tibbits, **NP**
Rachel Bossi, **PA**
Alisabeth Walburn, **PA**
Ann Marie Harper, **PA**
Sarah Decker, **NP**
Nancy Popps, **NP**

PATIENT REGISTRATION

INITIAL APPOINTMENT DATE_____ / _____/ _____

NAME_____ **DATE OF BIRTH**_____ /_____/_____

ADDRESS _____

HOME PHONE _____ **CELL PHONE** _____

EMAIL ADDRESS _____

Medications

Please list below all drugs and medications taken over the last week
(include birth control pills, aspirin and any kinds of over the counter drug or medication of any kind)

Name of Drug or Medicine	Dosage If Known	How Many Per Day	How Helpful is it? (a lot) (some) (none)	Any Side Effects? (yes) (no)	If Yes what is it? (GI) (Skin) (Other)
☐ Please check box if you are not taking any prescribed or over the counter medications at this time.					

Pharmacy Information

Pharmacy Name		**Phone #**		**Address**	
Pharmacy Name		**Phone #**		**Address**	

Signature:_____ Date:_____

5794 Widewaters Parkway • Syracuse • NY • 13214
Phone (315) 422-1513 • Fax (315) 476-5950
www.ahasyr.com

AHA Arthritis Health Associates

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HIPAA POLICY

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are committed to maintaining the privacy of your personal health information (PHI).
Your PHI will be used in the normal course of business for treatment and to bill you and/or your insurance company for payment of our services. Please assist us in clarifying with whom and how we may communicate information concerning your care.

PRINT PATIENT NAME: _____ **DOB:** _____

Email: _ _____

Home phone #:_____ **Cell Phone #:**_____

PREFFERED Method of contact (choose one): ☐**Text Message** ☐**Home Call** ☐**Cell Call**

AHA may remind me about a **FUTURE OFFICE APPOINTMENT**

Check all that apply…. *HOME/CELL VOICEMAIL:* ☐**YES** ☐**NO**
WITH ANOTHER PERSON (please list names & contact information below): ☐**YES** ☐**NO**
LETTER: ☐**YES** ☐**NO**

AHA may communicate my **PERSONAL MEDICAL INFORMATION** (lab results, treatment plans, etc):

Check all that apply…. *HOME/CELL VOICEMAIL:* ☐**YES** ☐**NO**
WORK VOICEMAIL: ☐**YES** ☐**NO**
WITH ANOTHER PERSON (please list names & contact information below): ☐**YES** ☐**NO**
LETTER: ☐**YES** ☐**NO**

☒ **AHA may contact my pharmacy and obtain my past medication history.**
☐ I prefer to not release my past medication history.

☐ **Patient Portal Care Manager (indicate below):**
(another individual you give permission to access your Patient Portal Account):

Name:_____**Email**_____

My **PERSONAL MEDICAL INFORMATION** may be discussed with the following relatives, friends, healthcare proxies, caregivers, etc. (please do not list referring physicians):

CONTACT NAME	RELATIONSHIP	PHONE #	CELL PHONE #

Please list here any *additional instructions* you may have regarding how Arthritis Health Associates handles your **PERSONAL MEDICAL INFORMATION:**

Updated 4/21/23

Signature:_____ Date:_____

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From the North
Take I-81 South toward Syracuse
Take exit #29S onto I-481 South toward Dewitt
Take exit #4 onto I-690 West toward Syracuse
Take exit #17/Bridge Street
Turn right on Bridge Street
Turn left on Widewaters Parkway

From the South
Take I-81 North
Take exit #16A onto I-481 North toward Dewitt
Take exit #3W and merge onto Rt. 5 West/Rt. 92 West/East Genesee toward Dewitt
Turn right to follow Rt. 5 West/Erie Blvd. East
Turn right on Kinne Road
Turn left on Widewaters Parkway

From the West
Take the I-90 East
Take exit #39 onto I-690 East toward Syracuse
Take exit #16-17/Rt. 635
Turn right onto Bridge Street
Turn left on Widewaters Parkway

From the East
Take I-90 West toward Buffalo
Take exit #34A onto I-481 South toward Syracuse
Take exit #4 onto I-690 West toward Syracuse
Take exit #17/Bridge Street , turn right on Bridge Street
Turn left on Widewaters Parkway

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Arthritis Health Associates PLLC

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Arthritis Health Associates** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **ARTHRITIS HEALTH ASSOCIATES** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for **ARTHRITIS HEALTH ASSOCIATES** to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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

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

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