INTERNAL MEDICINE/FAMILY PRACTICE
Nady R. Shehata, M.D.
President
Nancy J. Peters, M.D., V. President
Andrew W. Warner, M.D., Secretary

Albert J. Addesa, Jr., M.D.
Jacqueline M. Heim, D.O.
Adam R. Kawinski, M.D.
Nathan D. Rush, PA-C
Brenda F. Heim, PA-C
Kaylin C. Watt, PA-C
Maegan E. Humel, PA-C
Kelsey E. Irving, PA-C
Sarah E. Graham, PA-C
Anthony Gengo, PA-C

Associated Physicians of Western New York, P.C.

Internal Medicine / Family Practice

James P. Giambrone, M.D.
Physician Emeritus

Dawn Benedict
Practice Supervisor

Samantha Iannarelli, RN, BSN
Nurse Manager

PLEASE READ IMMEDIATELY

Date: _____

Dear: _____

Our records indicate that your initial visit to our office is scheduled

on _____ with _____ .

For your first visit to proceed smoothly, we are requesting that you complete the enclosed six (6) forms *PRIOR* to your appointment. **On the day of your appointment, we ask that you arrive 10-15 minutes early.** Please bring the forms, your driver's license (or photo ID), your insurance card and your actual medication bottles or anything you take over the counter with you.

PLEASE NOTE: It may be necessary for you to have selected a Primary Care Physician (PCP) from this office prior to your appointment in order for your visit to be covered by your insurance. Be advised that any co-payment or monies due, are payable at the time of service. We do not bill for co-payments. We accept cash, checks, debit and most major credit cards.

For your convenience, we have enclosed a copy of our practice brochure. Please take a few moments to read over our office policy before your appointment and address any concerns you may have with our office staff. You may also visit our website at apwny.com

If for any reason you are unable to keep your scheduled appointment, please call the office as soon as possible to inform our staff to cancel. These appointments are saved for you and require extensive time. We will contact you to confirm your appointment 48-72 hours prior. It is necessary for you to return the call and let us know that you will be keeping this appointment or it will automatically be cancelled. Please be sure to contact the office to acknowledge your appointment as instructed.

UNCANCELLED NEW PATIENT APPOINTMENTS THAT ARE MISSED WILL NOT BE RESCHEDULED.

Thank you in advance for your cooperation.
Front Desk Reception Staff

1616 Kensington Avenue
Buffalo, New York 14215
(716) 835-3097
Fax (716) 837-4654

2805 Wehrle Drive, Ste. 10
Williamsville, NY 14221
(716) 683-5252
Fax (716) 683-6885

Associated Physicians of Western New York, P.C.

Internal Medicine/Family Practice

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone #: _____Cell Phone #: _____

Cell Phone Carrier: _____

Marital Status:_____Birth Date:_____Social Security #:_____

Sex at Birth: _____ Gender Identity: _____ Race: _____

Ethnicity: _____Language: _____

Email Address:_____

Employer Name:_____

Occupation:_____ Employer Phone #:_____

Emergency Contact Name: _____

Contact Phone #:_____ Relationship:_____

Who referred you to this office?_____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: (if available) _____

Authorization to release information: I hereby authorize the physician to release any necessary information acquired during treatment to process insurance claims.

Signature:_____ Date: _____

Authorization to pay benefits to physician: I hereby authorize the insurance company to pay medical benefits directly to the physician, if any are paid. If the insurance company does not pay the claim, I realize I may be responsible for non-covered services.

Signature:_____ Date:_____

ASSOCIATED PHYSICIANS OF WNY, P.C.

General Information Sheet

Please answer the following questions prior to your first examination so we can better serve you.

NAME: _____ DOB: _____ AGE: ____

PHONE NUMBER: _____ PLACE OF BIRTH (COUNTRY): _____

ADDRESS: _____

HIGHEST EDUCATION LEVEL: _____ OCCUPATION: _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____

MEDICAL DIAGNOSES: Please include all medical problems that you are currently being treated for or have been treated for in the past.

_____

_____

_____

MEDICATIONS: Please list all medications including over the counter medications and vitamins/minerals. If needed, please attach a list.

MEDICATION	DOSE	REASON FOR TAKING	PREVIOUS/CURRENT PRESCRIBER

ALLERGIES: Please include medications you are allergic to and the reaction you had to them.

_____

PAST SURGERIES: _____

_____

FAMILY HISTORY:

Father: Alive [ ] or Deceased [ ] Current/Past Medical Problems: _____

_____

Mother: Alive [ ] or Deceased [ ] Current/Past Medical Problems: _____

_____

Siblings: Current/Past Medical Problems: _____

Children: Current/Past Medical Problems: _____

Other Family Members (grandparents, aunts/uncles, etc) _____

OVER

SOCIAL HISTORY:

Do you currently smoke? YES [ ] NO [ ]

If YES: How many packs per day and for how many years? _____

Any interest in quitting? _____

If NO: Have you in the past? _____

How long has it been since you quit? _____

How much did you used to smoke and for how many years? _____

Any alcohol use? YES [ ] NO [ ]

If YES: How many times a week do you drink? _____

How many drinks per occasion? _____

Do you ever drink more than 6 drinks per occasion? _____

Do you use any recreational or illegal drugs? YES [ ] NO [ ]

BEHAVIORAL HEALTH:

- Personal history of:

Mental Health: _____

Substance Abuse: _____

- Family History of:

Mental Health: _____

Substance Abuse: _____

SPECIALISTS: If you follow with any other physicians currently, please list them below and include what you are seeing them for. Women, please include your OBGYN.

PHYSICIAN: REASON FOR SEEING:

_____

_____

_____

_____

_____

Health Care Proxy: If you have a health care proxy, please include their name here

_____

PREVIOUS VACCINATIONS: Please include the dates of previous vaccinations if received.

Influenza Vaccine: _____

Pneumonia Vaccine: _____

Shingles Vaccine: _____

PREVENTATIVE MEDICINE: Please include the dates of all of the following procedures if received.

Mammogram (women only): _____

Pap Smear (women only): _____

Colonoscopy (men and women over 50): _____

Bone Density Scan (women over 65): _____

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To Our Patients:

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, a significant other, a parent or sibling, or any other individual, you must indicate the name of that specific person(s). WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.

I, _____, hereby give my permission for the staff of
(Your Name)

Associated Physicians of WNY to release medical information about myself to:

_____
(Name of person you are authorizing) (Relationship) Phone#

_____
(Name of person you are authorizing) (Relationship) Phone#

I may cancel this authorization at any time by written notification.

Signature: _____ Date Signed: _____

**** IF YOU DO NOT WANT TO AUTHORIZE THE RELEASE OF YOUR MEDICAL INFORMATION TO ANY INDIVIDUAL, PLEASE SIGN BELOW.**

I, _____, decline to have any medical
(Your Name)

information released to any individual.

Signature: _____ Date Signed: _____

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Buffalo, New York 14215
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Fax (716) 683-6885

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:
Associated Physicians of WNY, P.C. 1616 Kensington Avenue Buffalo, NY 14215

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.**

ASSOCIATED PHYSICIANS OF WESTERN NEW YORK, P.C.
1616 Kensington Ave., Buffalo, NY 14215

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by **Associated Physicians of WNY, P.C.** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
Associated Physicians of WNY, P.C. is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, **Associated Physicians of WNY, P.C.** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request.

It is a violation of the federal privacy standards if **Associated Physicians of WNY, P.C.** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request.

YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime; however, **Associated Physicians of WNY, P.C.** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
Associated Physicians of WNY, P.C. reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. **Associated Physicians** will notify you of any changes of privacy practices either by mail or at your next appointment.

SIGNATURE
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Polices and Practices" and give my permission to **Associated Physicians of WNY, P.C.** to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Print or Type)	Signature of Patient / Date
Patient Representative (Print or Type)	Signature of Representative / Date
Relationship of Patient Representative to Patient	

Associated Physicians of Western New York, P.C.

1616 Kensington Avenue
Buffalo, New York 14215
Phone 716-835-3097
Fax 716-837-4654

2805 Wehrle Drive Suite 10
Williamsville, New York 14221
Phone 716-683-5252
Fax 716-683-6885

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form provides authorization to our practice to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

Patient Name:_____ DOB: _____

Address: _____

- Who will be disclosing the information? Name of person or entity, or category of persons/entities authorized to make the requested use of disclosure:

_____

_____

- Who will be receiving or using this information? Name of person or entity, or category of persons/entities, to whom the use of disclosure may be made:

_____

_____

- What information will be used or disclosed? The following is a specific description of the information to be used or disclosed, but not limited to, the date(s) of service provided, level of detail to be released, origin of information, etc.:

_____

_____

- What is the purpose of the use and disclosure? This information is being used or disclosed for the specific purpose(s) below. If you have requested use or disclosure of the information but do not, or elect not to, provide a statement of purpose, we will state "at the request of the individual".

_____

_____

This authorization will expire on (Date): _____

Signatures: I have read and understand the terms of this authorization, and I understand that I may revoke this authorization in writing to the appropriate person.

_____ _____

Patient – Print name above Date

_____

Patient Signature

_____ _____

Witness Signature Date

Revised 03/21/13