Brockport Vine Medical
Alex Fahoury, MD
122 West Ave Suite 6B
Brockport, NY 14420
Phone: (585) 391-3040
Fax: (855) 838 - 5149

Patient Information

Name: _____ **Your Date of birth:** _____

Address _____

City : _____ **Zip code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Social Security #:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Emergency Contact Phone #: _____

Billing information

Person responsible for bill: _____ **D.O.B.** _____

Relationship: _____ **Address (if different):** _____

Insurance information

DOB of the Policy Holder and their address: _____

Primary-Insurance: _____ **Policyholder's-name:** _____

ID # _____ **Group #** _____

Secondary-insurance: _____ **Policyholder's-name:** _____

ID # _____ **Group #** _____

It is the patient's responsibility to pay deductibles, co-insurance and/ or co-pays on the date of service, and to pay any other balance not paid for by insurance. If we are filling your claim, we will allow 45 days from the filing date for the carrier to process your claim and payment. If an insurance payment is not received within its time frame, we will notify you to clear your account. Insurance filling is done as a courtesy to you and does not dismiss your responsibility to pay for services. Self pay patients must pay for their services on the day in which they are rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by the insurance carrier.
I hereby authorize said assignee to release all information necessary to secure payment. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. Should the account be referred to an attorney collection the undersigned shall pay reasonable attorneys fees and collection expenses.

Signature: _____ **Date:** _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with federal government privacy rule implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your healthcare provider or a staff member of The Vine Medical Center to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ **I DO NOT** authorize The Vine Medical Center to release any information concerning my medical care to any individual.

____x____**I DO** authorize The Vine Medical Center to verbally release any or all information concerning my medical care to the following individuals:

Name:_____Relationship: _____

Name:_____Relationship: _____

Patient signature: _____Date:_____

Witness signature: _____Date:_____

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MEDICAL RECORDS RELEASE REQUEST

Patient Name_____ **D.O.B.** _____

Address: _____**City:** _____ **State:** _____

Zip Code: _____ **Social Security #** _____ **Phone:** _____

THE FOLLOWING FACILITY IS AUTHORIZED TO PROVIDE COPIES OF THE PATIENTS IDENTIFIABLE HEALTH INFORMATION:

RELEASE FROM:

Name: _____

Address: _____

Phone # _____ **Fax #** _____

SEND TO:

DR. ALEX FAHOURY, MD **PHONE # (585) 391-3040**

122 WEST AVE SUITE 6B **FAX # (855) 838 -5149**

BROCKPORT, NY 14420

PURPOSE FOR RELEASING THE INFORMATION

❑ **MOVING FROM AREA** ❑ **TRANSFER OF CARE** ❑ **AT PATIENTS REQUEST** ❑ **CONTINUATION OF CARE**

INFORMATION TO BE RELEASED

❑ **OFFICE/ TREATMENT NOTES** ❑**LABS** ❑**IMAGING (XRAY, CT, MRI)** ❑**EKG** ❑**OTHER**

PLEASE INDICATE THE DATES OF SERVICE TO BE RELEASED

❑ **ENTIRE MEDICAL RECORDS FOR SERVICES RENDERED AT THIS OFFICE**

❑**LAST OFFICE NOTE, LABS, AND / OR X-RAY TEST RESULTS**

❑ **OTHER (PLEASE SPECIFY)** _____

I UNDERSTAND THAT IF MY RECORDS CONTAIN DOCUMENTATION OF ALCOHOL ABUSE, PSYCHIATRIC CONDITION, DRUG ABUSE, OR COMMUNICABLE DISEASE, THIS INFORMATION WILL BE RELEASED AS PART OF MY RECORD. I UNDERSTAND THAT IF THE PERSON OR FACILITY RECEIVING THIS INFORMATION IS NOT COVERED BY FEDERAL PRIVACY REGULATIONS THIS INFORMATION WILL NO LONGER BE PROTECTED AND MAY BE RE-DISCLOSED. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT. I UNDERSTAND THAT I MAY REVOKE THE AUTHORIZATION AT ANYTIME, BUT REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN DISCLOSED. NOTE: THE REVOCATION MUST BE IN WRITING AND DELIVERED TO THE ABOVE ADDRESS OF THE PERSON / ENTITY OF WHOM WAS TO RELEASE INFORMATION. I UNDERSTAND THAT UNLESS EARLIER REVOKED, THIS AUTHORIZATION WILL EXPIRE 30 DAYS AFTER THE DATE SIGNED. I UNDERSTAND THAT THEIR MAY BE A CHARGE FOR OBTAINING THE REQUESTED INFORMATION, RELATED CHARGES CAN BE OBTAINED BY CONTACTING THE MEDICAL RECORDS DEPT. I UNDERSTAND THAT I HAVE THE RIGHT TO OBTAIN A COPY OF THIS AUTHORIZATION.

PATIENT SIGNATURE:_____ **DATE:** _____

TELEMEDICINE (VIDEOCONFERENCING) CONSENT

1. I authorize _____ to allow me to participate in a telemedicine (videoconferencing) service with Dr. Alex Fahoury, MD.
2. The type of service to be provided by via telemedicine is : _____
3. I understand that this service is not the same as a direct patient / healthcare provider visit, because I will not be in the same room as the healthcare provider performing the service. I understand that there are parts of my treatment and examination which cannot be accomplished because this is not a face-to-face meeting.
4. The nature and purpose of the videoconferencing technology have been fully explained to me. I have also been informed of expected risks, benefits and complications (from known and unknown causes), discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician face-to-face. The risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my healthcare provider or I can discontinue the telemedicine service, if we believe that the video conferencing connections are not adequate for the situation.
6. I agree to permit my healthcare information to be shared with other individuals for the purpose of scheduling and billing.
7. I acknowledge that I have the right to request the following: Emission of specific details of my medical history / physical examination that are personally sensitive, or termination of the service at any time. 8. I understand that I will be billed by my telemedicine healthcare provider.
9. It is the responsibility of the telemedicine provider to conclude the service upon termination of the video conference connection.
10. My consent to participate in the telemedicine service shall remain in effect for the duration of the specific service identified above or until I revoke my consent in writing.
11. No guarantees or assurances have been made about the results of the service.
12. I confirm that I have read and fully understand the above information. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

_____ _____

Patient/Relative/Guardian **Patient Name**

_____ _____

Relationship to Patient **Date/Time**

_____ _____

Witness **Date/Time**

_____ _____

Interpreter (IF required) **Date/Time**

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

_____ I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed telemedicine session, have offered to answer any questions and have fully answered all such questions. I believe that the Patient / Relative / Guardian fully understands what I have explained and answered.

Physician's signature:_____ **Date:**_____