Insurance Verification and Referring Physician

Date of Birth	Age	Gender	Marital Status	SSN or Last 4 digits

First Name	Middle Initial	Last Name

Phone Number	Email

Address	Apt #	City	State	County	ZIP Code

Employer Name	Work Phone & Extension

Work Address

Please provide the Doctor(s) information who referred you to the Gastroenterologist and do you want a report sent to your physician: ____Yes No____

Dr. Name: _____
Address: _____
Telephone: _____
Fax(required):_____

Dr. Name: _____
Address: _____
Telephone: _____
Fax(required):_____

1. Primary Insurance Name	Primary Insurance Address or Po Box

Policy Number / Member ID	Group

• Policy Holder Name	Date of Birth	Relationship	Social Security #

2. Secondary Insurance Name	Secondary Insurance Address or Po Box

Policy Number / Member ID	Group

• Policy Holder Name	Date of Birth	Relationship	Social Security #

SIGNATURE	TODAY'S DATE

New York State Department of Health

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

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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 Kips Bay Endoscopy Center LLC to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

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 Kips Bay Endoscopy Center LLC to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Kips Bay Endoscopy Center LLC to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

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)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May 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 about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. 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 include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

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

6. **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 at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Kips Bay Endoscopy Center LLC at 212-889-5477; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix 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 decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

KBEC
KIPS BAY ENDOSCOPY CENTER, LLC

Covenant Physician Partners

Coronavirus Patient Screening Tool

PATIENT PRESCREEN OR DAY OF VISIT QUESTIONNAIRE:

1. Previous COVID-19 (SARS-CoV-2-RNA) Did you test?: ☐ **Yes** ☐ **No** / Results: ☐ **Positive** ☐ **Negative**
   COVID-19 **Test Date:** _____/_____/_____**(month/day/year)**

2. COVID-19 Vaccination : ☐ **Yes** ☐ **No** / **Manufacturer:**_____ (Please complete the Following)
   Date of **1**st *Pfizer*/*Moderna* vaccine**:** _____/_____/_____ **(mo/day/yr)** Or Schedule on**:** _____/_____/_____
   Date of **2**nd *Pfizer*/*Moderna* vaccine**:** _____/_____/_____ **(mo/day/yr)** Or Schedule on**:** _____/_____/_____
   Date of *Johnson & Johnson* vaccine**:** _____/_____/_____ **(mo/day/yr)** Or Schedule on**:** _____/_____/_____

3. Are you experiencing any symptoms of respiratory illness, fever, chills, cough, difficulty breathing, shortness of breath, sore throat, loss of taste or smell or GI symptoms of diarrhea or headache or myalgia (muscle ache)?
   ☐ **Yes** (and circle symptom reported) ☐ **No**
   If **"Yes"**, approximately how long ago did you first notice symptoms? ____Hours ____Days____Weeks

4. **Temperature at visit: _____ºF _____ºC**

5. In the past 14 days, have you traveled internationally or outside New York State? ☐ **Yes** ☐ **No**
   If "**Yes**", where to? _____

6. In the past 14 days, have you had close contact with a person known to have 2019-nCOV (Coronavirus)?
   ☐ **Yes** ☐ **No**

➢ [_____] [_____] [_____]
PRINT YOUR FULL NAME YOUR SIGNATURE DATE

❖ Please Provide **Escort's**: _____
First Name **Relationship** **Phone Number**

❖ Living Will ***or*** Health Care Proxy Provided?: ☐ **Yes** ☐ **No**

Staff Only: If Patient screens positive, notify the attending physician for directions.

Screener Signature: _____ **Date:** _____

Inform patient if a mask is provided, it does not prevent spreading of the Coronavirus but is effective against the spread of the flu.
Note: any ***positive*** response or ***temperature ≥100.4ºF,*** is considered a positive screening.

Staff Only: Case Cancelled: ☐ Yes
Mask Provided: ☐ Yes ☐ No Notified Public Health Department: ☐ Yes ☐ No
Patient Referred to: ☐ Primary Care Physician ☐ Emergency Room ☐ Public Health Department
Urgent Care: ☐ ☐ Other: _____