USHA THOMAS
175 GUYON AVENUE
Staten Island, NY, 10306

PATIENT DEMOGRAPHICS

Last Name	First Name	M.I.
Date of Birth	Age	M / F	Race
Home Address	City	State	Zip Code
Home Phone	Patient Phone (if any)

INSURANCE

Primary	Member ID
Secondary	Member ID

PARENT INFORMATION

Mother's Name	DOB	Cell Phone
Father's Name	DOB	Cell Phone
Is the home address the same as above?	Yes / No	If not, please enter below.
Home Address	City	State	Zip Code
Email Address

PREFERRED PHARMACY

Name	Address

EMERGENCY CONTACT

Name	Relationship to Patient
Home Phone	Cell Phone

USHA THOMAS
175 GUYON AVENUE
Staten Island, NY, 10306

FINANCIAL POLICY

Please verify your insurance coverage before you visit our office. If your insurance policy requires a doctor's name to be specified, please make sure that Dr. Thomas is listed as the Primary Care Provider (PCP). If Dr. Tomas does not participate in your plan, there will be an out-of-network charge, which will be your responsibility. Referrals (if required by your plan), must be requested at least a week in advance. Frequency of "Well" visits that are allowed by your insurance company should be confirmed by you. Hearing and Vision tests, as well as some immunizations may not be covered under your plan.

Should there be any change to your insurance coverage or contact information, please ensure our office is made aware of the change(s). It is very important for us to have your latest information to avoid billing you services rendered.

Copayments are due at the time of your visit. Any outstanding bills should be settled before the time of your visit. If you do not have insurance coverage, you are responsible for the entire charge for your visit. Payment can be made by credit card (except American Express), check, or cash. You will be billed for any deductibles and/or coinsurance that is required by your insurance.

AGREEMENT

I certify that the information provided by me in the 'Patient Demographics' form is true and accurate to the best of my knowledge. I will notify your office of any change(s) in the future and also read all the information provided in the 'Financial Policy' above and I realize that I am ultimately responsible for any balance on my account, towards professional services provided to me.

I hereby give Usha Thomas, M.D.,P.C., my consent for any necessary medical evaluations and treatment for my child including but not limited to the administration of all age appropriate and indicated vaccines currently recommended by the CDC. If you refuse any of the indicated vaccines for your child you will be provided with a refusal to vaccinate document.

Representative's Name: _____
Relationship to Patient: _____
Signature: _____ Date:_____

NOTICE OF PRIVACY PRACTICE

- ❑ I am interested in receiving a copy of the 'Notice of Privacy Practice'
- ❑ I am not interested in receiving a copy of the 'Notice of Privacy Practice'

Company Name
Address
Phone Number

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 Dr. Thomas (including their agents) 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 Dr. Thomas to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Dr. Thomas 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)

USHA THOMAS
175 GUYON AVENUE
Staten Island, NY, 10306

TELEHEALTH ACKNOWLEDGMENT AND CONSENT FORM

1. I understand that my health care provider, Dr. Usha Thomas has recommended to me that I engage in a telehealth appointment with my child and I when I called the office to make an appointment.
2. My health care provider has explained to me how the telehealth technology will be used to connect my child and I with a provider. Telehealth appointments may be conducted by video conferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.
3. I understand that ym healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and this will have the right to request the following:
    a. Omit specific details of my medical history/physical examination that are personally sensitive to me
    b. Ask non-medical personnel to leave the telehealth examination room
    c. Terminate the telehealth appointment at any time
4. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the primary care provider.
5. I understand that if the provider is unable to fully evaluate the patient during the telehealth visit, the primary care provider will advise me to follow up in the office for an in-person visit. I also understand that in an emergency situation, the responsibility of the telehealth provider may be to direct me to emergency medical services, such as the emergency room.
6. I understand that billing for the telehealth consultation may occur from the primary care provider including copays and deductibles, and if insurance doesn't cover Telehealth visits, I will be charged a flat fee for the service. Billing is at the discretion of the provider.
7. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment under the terms described herein.

Name of Patient: _____ DOB:_____Date:_____
Name of Guardian:_____ Signature:_____