Registration :

K Kantu, MD

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home: / Work: / Cell:	How did you hear of us?
[redacted] Apt#	Email:	
City / State / Zip Code	Employer Name & Address	Occupation
Emergency Contact / Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:
City / State / Zip Code	Employer Name & Address		Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:
City / State / Zip Code	Employer Name & Address		Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to K Kantu, MD , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	
X		**K Kantu, MD** 2204 Voorhies Avenue Brooklyn, NY 11235 Phone: 718-646-2500 Email:

Please attach all pertinent insurance ID cards for photocopying.

NY Center For
Ear, Nose, Throat, Sinus & Allergy, LLP

KANHAIYALAL KANTU, M.D., F.A.C.S.
SANJAY KANTU, M.D.
MANOJ KANTU, M.D.
DIPLOMATES AMERICAN BOARD
OF OTOLARYNGOLOGY

SINUS & ALLERGY
FACIAL PLASTIC SURGERY
HEARING & BALANCE DISORDERS
SNORING & SLEEP APNEA
HEAD & NECK SURGERY

MEDICAL HISTORY

Today's Date_____ Birth date (MM/DD/YYYY)_____

Name:_____
Last First

ALLERGIES ☐NONE ☐YES - PLEASE LIST _____

LIST CURRENT MEDICATIONS (include all non-prescription medications you take)_____

_____

_____

PLEASE CHECK CURRENT/CHRONIC MEDICAL CONDITIONS ☐ NONE

☐acid reflux	☐depression	☐high cholesterol	☐thyroid disease
☐anemia	☐emphysema	☐HIV	☐tuberculosis
☐anxiety	☐gallbladder	☐irregular heart beat	☐ulcers
☐arthritis	☐glaucoma	☐kidney	
☐asthma/allergies	☐gynecologic dis.	☐migraine	
☐bleeding/clotting disease	☐lupus	☐parathyroid disease	
☐breast disease	☐headaches	☐pneumonia	
☐bronchitis	☐heart attack date_____	☐rheumatoid arthritis	
☐cancer of _____	☐heart disease	☐sarcoidosis	
☐chronic lung disease	☐hepatitis B	☐seizures/epilepsy	
☐COPD	☐hepatitis C	☐skin condition (eczema/psoriasis)	
☐diabetes	☐high blood pressure	☐stroke date _____	

OTHER MEDICAL CONDITIONS: _____

SURGERIES (DESCRIBE TYPE & YEAR) _____

Tobacco Usage: ☐ NO ☐YES. If yes: PACKS PER DAY _____

Alcohol Use: ☐NO ☐Yes. If Yes, ☐Occasional ☐Weekly ☐Daily

Patient Signature _____

Sheepshead Bay, 2204 Voorhies Avenue, Brooklyn, N.Y. 11235 • Phone: (718) 646-2500 • Fax: 648-4583
9015 5th Ave., Brooklyn, N.Y. 11209 • Phone: (718) 745-1701
www.nycent.com

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NOTICE OF PRIVACY PRACTICES --- PATIENT ACKNOWLEDGEMENT

Patient's Name:_____ Date of Birth: _____

I have received this Practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made of this Practice, my individual rights, and the Practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this Practice is required by law to maintain the privacy of protected health information.
- A statement that this Practice is required to abide by the terms of the Notice currently in effect.
- Types of uses and disclosures that this Practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of the other purposes for which this Practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I exercise their rights in relation to:
    - The right to complain to this Practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a compliant.
    - The righto request restrictions on certain uses and disclosures of my protected health information, and that this Practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this Practice upon request.

This Practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this Practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

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Welcome to our Ear, Nose, and Throat Practice.

Please circle those items below that best describe your reasons for being here :

Hearing loss

Ear pain or itching

Ringing in the ears

Dizziness

Allergies

Sinus problem

Nasal congestion

Throat problem

Neck problem

Thank you!

Dr Kantu

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Your signature below forms a binding agreement between NY CENTER FOR E.N.T and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service. MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform NY CENTER OF E.N.T of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that NY CENTER OF E.N.T. has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) Patient Signature

_____ Date

Responsible Party Name (Please Print) Responsible Party Signature

_____ Date

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:

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.**