Mount Sinai DoctorsMS-MRN:_____

Facesheet

Patient's Name			Gender	Race/Ethnicity **(Please see back of sheet)**
Social Security Number	Age	Date of Birth	Marital Status	Religion
Patient's Address				Patient's Phone
Patient's E-Mail				Patient's Cell Phone
Patient's Preferred Language				Interpreter Needed? (YES/NO)

Employment Status	Employer Name	Employer Phone
Employer Address		Patient Work Phone

Referring Source	Referring Physician	Primary Care Physician (PCP)
Referring Source Phone Number	Referring Physician Number	Referring PCP Phone Number

Next of Kin	Relationship to Patient	NOK Phone	NOK Address
Emergency Contact	Relationship to Patient	EMC Phone	EMC Address

Insurance Health Plan Name (1)	Policy Number	Group Name	Group Number
Health Plan Type	Financial Class		
Health Plan Address			Health Plan Phone
Subscriber Name	Relationship to Patient		Subscriber Date of Birth
Subscriber Employer Name	Employment Status		Subscriber Phone

Insurance Health Plan Name (2)	Policy Number	Group Name	Group Number
Health Plan Type	Financial Class		
Health Plan Address			Health Plan Phone
Subscriber Name	Relationship to Patient		Subscriber Date of Birth
Subscriber Employer Name	Employment Status		Subscriber Phone

Demographic Verification

I have reviewed the demographic and insurance information provided on the facesheet. The above information is correct and accurate.

Signature

X

TODAY'S DATE_____

MEDICAL HISTORY

NAME _____ AGE _____ BIRTHDATE _____

ADDRESS _____ SEX M ☐ F ☐

_____ HOME PHONE _____

_____ WORK PHONE _____

OCCUPATION _____ EMERGENCY CONTACT _____

RELATIONSHIP _____

PHONE _____

SPOUSE, PARTNER, SIGNIFICANT OTHER'S NAME:

CHILDREN'S NAME AND AGES:

Allergies to medications, X-Ray Dyes, or other substances ☐ **NO** ☐ **YES**
(if yes, please list name of medicine/substance and reaction):

MEDICAL HISTORY

Please circle if you have had problems with or are presently experiencing any of the following:

High Blood Pressure
Diabetes
Cancer
type

Heart Disease
Heart Attack
High Cholesterol

osteoporsis
Rheumatic Fever

Asthma
Emphysema
Chronic Bronchitis
"COPD"
Pneumonia
Tuberculosis

Constipation
Blood in Stool
Ulcer

Weight Loss

Gall Bladder Disease
Colitis
Hepatitis or Jaundice
Thyroid disease
Head or Neck Radiation

Kidney Disease
Kidney Stones
Prostate Disease

Arthritis
Low Back Problems
Gout

Skin Disease
Headache
Menstruation Disorder
Anemia

Venereal Disease
Anxiety
Depression

Alcohol Difficulty
Drug Use

Pregnancy

OTHER:

Please list hospitalizations (including surgery) and their dates:

t

TURN OVER FOR 2nd PAGE

List immunizations you have had:

Date	Date	Date	Date
Hepatitis A	Flu	Tetanus	Other
Hepatitis B	Pneumovax	Measles/Mumps/Rubella	

When was your last:

Date	Date	Date
PAP Smear	Breast Exam	Cholesterol Check
Mammogram	Prostate Exam	Colonoscopy
Bone Density		

FAMILY HISTORY

Has any member of your family(parents, grandparents,brothers,sisters,etc)had the following?
Please note the age when diagnosed!

	Which family member(s)?	AGE Diagnosed
Cancer(breast,colon,prostate,skin)		
Hypertension (high blood pressure)		
Heart disease/heart attack		
Stroke		
Diabetes		
High Cholesterol		
Mental disease (depression, anxiety, etc)		
Drug or Alcohol Addiction		
Glaucoma		
Thyroid disease		
Other		

MEDICATION (Prescription, Over-the-Counter, Vitamins, Herbs, Homeopathic)

name	*dose*	*name*	*dose*	*name*	*dose*

PREVENTION	NO	YES	
Do you exercise? How often?			
Do you have a living will? Health care proxy?			
Do you have a donor card?			
Do you smoke?			How much /week?
Do you drink alcoholic beverages?			How much /week?
Do you drink coffee?			How much/day?
Do you drink tea?			How much day?
Do you use drugs? (marijuana, cocaine, etc)			Explain:
Do you wear seat belts?			
Have you ever been threatened, or physically hurt (slapped, kicked, punched, etc) by your partner?			
Do you ever feel afraid of your partner?			
If there is a gun in your home, is it out of childrens' reach and unloaded?			
Have you ever engaged in any activity which has put you at risk for AIDS?			Explain:
Do you wish to be tested for AIDS?			
Method of birth control? Not applicable?			
Have you ever worked with hazardous materials?			Explain:

Mount Sinai

A Message to Our Patients

Hospitals are required to collect race and ethnicity information on all patients by the Department of Health (DOH). Racial and ethnic backgrounds may place people at different risks for certain diseases. By knowing more about your racial and ethnic background, we can better meet your health needs. Please review the selections on this card and select the ethnicity and race that best describes you.

RACE DESCRIPTION	
I	AMERICAN INDIAN OR ALASKA NATIVE
SEE BELOW	ASIAN
SEE BELOW	BLACK
SEE BELOW	NATIVE HAWAIIAN OR PACIFIC ISLANDER
W	WHITE
O	OTHER
U	UNKNOWN

ETHNICITY DESCRIPTION	
SEE BELOW	SPANISH/HISPANIC ORIGIN
N	NOT HISPANIC OR LATINO
U	UNKNOWN

ASIAN (Please Select One From the Options Below)	
AA	Asian Indian
AB	Bangladeshi
AC	Bhutanese
AD	Burmese
AE	Cambodian
AF	Chinese
AG	Filipino
AH	Hmong
AY	Indonesian
AJ	Iwo Jiman
AK	Japanese
AL	Korean
AM	Laotian
AO	Malaysian
AP	Maldivian
AQ	Nepalese
AR	Okinawan
AZ	Pakistani
AT	Singaporean
AU	Sri lankan
AV	Taiwanese
AW	Thai
AX	Vietnamese

BLACK (Please Select One From the Options Below)	
BA	African-American
BB	Barbadian
BC	Cape Verdian
BD	Congolese
BE	Dominica Islander
BF	Eritrean
BG	Ethiopian
BH	Gabonian
BJ	Ghanaian
BK	Grenadian
BM	Guinean
BN	Haitian
BO	Ivory Coastian
BP	Jamaican
BQ	Kenyan
BR	Liberian
AN	Madagascar
BS	Malian
BT	Nigerian
BU	Senegalese
BV	Sierra Leonean
BW	Somalian
BX	St Vincenian
BY	Sudanese
BZ	Tanzanian
B1	Togolese
B2	Trinidadian
B3	Ugandan
B4	West Indian
B5	Zimbabwean
B6	Other: East African
B7	Other: North African
B9	Other: West African
B8	Other: South African

NATIVE HAWAIIAN OR PACIFIC ISLANDER (Please Select One From the Options Below)	
PA	Carolinian
PB	Chamorro
PC	Chuukese
PD	Fijian
PE	Guamanian
PF	Guamanian or Chamorro
PG	Kiribati
PH	Kosraean
P1	Mariana Islander
PJ	Marshallese
PK	Melanesian
PL	Micronesian
PM	Native Hawaiian
PN	New Hebrides
PP	Palauan
PQ	Papua New Guinean
PR	Pohnpeian
PS	Polynesian
PT	Saipanese
PU	Samoan
PV	Solomon Islander
PW	Tahitian
PX	Tokelauan
PY	Tongan
PZ	Yapese
PO	Other Pacific Islander

SPANISH/HISPANIC ORIGIN (Please Select One From the Options Below)	
1	Andalusian
2	Argentinean
3	Asturian
4	Belearic Islander
5	Bolivian
6	Canal Zone
7	Canarian
8	Castillian
9	Catalonian
10	Central American
11	Central American Indian
12	Chicano
13	Chilean
14	Colombian
15	Costa Rican
16	Criollo
17	Cuban
18	Dominican
19	Ecuadorian
20	Gallego
21	Guatemalan
22	Honduran
23	La Raza
24	Latin American
25	Mexican
26	Mexican American
27	Mexican American Indian
28	Mexicano
29	Nicaraguan
30	Panamanian
31	Paraguayan
32	Peruvian
33	Puerto Rican
34	Salvadoran
35	South American
36	South American Indian
37	Spaniard
38	Spanish Basque
39	Uruguayan
40	Valencian
41	Venezuelan

Mount Sinai

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by **Mount Sinai Doctors** ("Mount Sinai") with respect to such services and care unless the contract between Mount Sinai and my insurance company provides otherwise and/or unless otherwise provided by law. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to Mount Sinai, to cover the cost of the care and treatment rendered to myself or my dependents in the hospital.

Upon receipt of a Mount Sinai bill, I agree to immediately pay all amounts not covered by insurance unless otherwise provided by law. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to Mount Sinai for services rendered to me, I hereby give my consent to have an authorized representative of Mount Sinai contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by Mount Sinai which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize Mount Sinai, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of Mount Sinai charges and/or professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only Part A and Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or Mount Sinai Services to the physician (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that Mount Sinai is a participating provider in many health plan networks, and that a list of the plans that Mount Sinai participates in can be found at www.mountsinaihealth.org/insuranceinfo

I understand that physicians and other providers who render services at Mount Sinai may be employed or contracted by Mount Sinai, or may be independent practitioners who are **not** employed or contracted by Mount Sinai. I further understand that charges for physicians' and providers' "professional services" that I receive at Mount Sinai are **not** included in Mount Sinai's charges, and that physicians/providers may bill for their "professional services" separately from Mount Sinai.

I understand that physicians who provide services at Mount Sinai may not participate in the same health plans as Mount Sinai (even if they are employed or contracted by Mount Sinai). I understand that I can determine the health plans participated in by the physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting http://www.mountsinaihealth.org/insuranceinfo.

I understand that I can check with the physician(s) arranging for my hospital services to determine: (1) the name, practice name, mailing address and telephone number of any other physician/practice whose services will be arranged by the physician; and (2) whether the services of physicians who are employed or contracted by Mount Sinai to provide services (including anesthesiology, pathology and/or radiology) are reasonably anticipated to be provided to me. I further understand that I can determine the health care plans participated in by physicians/practices who are reasonably anticipated to provide services to me at Mount Sinai who are employees of or are contracted by Mount Sinai to provide such services (including anesthesiology, radiology, and/or pathology) by visiting http://www.mountsinaihealth.org/insuranceinfo. I further understand that I can check with the physician(s) arranging for my hospital services to obtain the contact information for any physicians/practices whose services may be needed in connection with my hospital care, and that I can contact those physicians/practices directly to obtain information regarding their health plan participation.

5. Patient Consent to the Release of Records for NYS External Appeal

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans. In the event an external appeal is filed, consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services, in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring action against my health plan

6. Patient Consent for Examination and Treatment

I, the undersigned, hereby authorize and request Mount Sinai to provide such medical care and to administer such diagnostic, radiological and/or therapeutic procedures and treatments; including but not limited to the administration of pharmaceutical products, injection, and intravenous medication or other therapeutic solutions as in the judgment of the physicians treating the patient named on this page may be deemed necessary or advisable.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ DATED _____

RELATIONSHIP TO PATIENT _____ WITNESS TO SIGNATURE _____

A patient under the age of 18 is emancipated and may sign consent for treatment if at least one of the following conditions has been met (circle any which apply):

- The patient is legally married
- The patient is or has been a parent
- The patient is self-supporting and does not reside with parents

A patient under the age of 18 may sign consent to treatment for venereal disease, abortion, and other related gynecologic and obstetric care.

Mount Sinai

Mount Sinai Health Information Exchange (HIE) and Healthix Consent Form

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called e-health or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants on the website will be updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of The Mount Sinai Hospital and Icahn School of Medicine at Mount Sinai (together, "Mount Sinai") to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization ("RHIO"), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE.

PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION

Your Consent Choices. You can full out this form now or in the future. You have the following choices:
Please check Box 1 or Box 2.

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of my electronic health information through the Mount Sinai HIE and I GIVE CONSENT TO ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.**

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access my electronic health information through the Mount Sinai HIE and I DENY CONSENT TO ALL employees, agents, and members of the medicals staff of Mount Sinai to access ANY of my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.**

Note: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will only be shared in an emergency as allowed by applicable law.

Print Name of Patient

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Dear Patient,

Thank you for using the Mount Sinai Health System. It has been our privilege to be of service. We recognize that many of our patients may not have the health insurance or the financial resources to access quality health care services without financial assistance. An integral part of Mount Sinai's mission is to deliver medical care to all persons in need, regardless of their ability to pay.

If you are unable to pay all or part of your hospital bill, you may:

- Apply for financial assistance if your income does not exceed 400% of the Federal Poverty Income Guideline. Copies of Federal Poverty Income Guidelines are available at the Department of Financial Counseling or on our website: www.HospitalAssistance.org
- Apply for financial assistance for medically necessary services, which include inpatient and outpatient services, emergency care, ambulatory surgery, clinic visits, and ancillary services such as CT scans, X-Rays and blood tests, if you reside in Brooklyn, Bronx, Manhattan, Queens or Staten Island. All other patients may apply for financial assistance for emergency services.
- Obtain applications for Hospital Financial Assistance, which are available in English, Chinese, Creole, Haitian, Polish, Russian and Spanish, at the Department of Financial Counseling or by visiting www.HospitalAssistance.org.
- Visit our team in the Department of Financial Counseling to help you determine whether you are eligible for financial assistance based on your financial situation. Our financial counselors will also work with you to arrange extended payment terms, based on your unique circumstances.
- Consult our language assistance services to anyone who has a need for an interpreter. Communicating with our staff is the most effective way to make sure you receive the care you need as soon as possible.

Please see the attached page for our Financial Assistance Office locations. Before coming to visit our offices, please complete Section 1 of the enclosed **Application for Financial Assistance** form. Even if you cannot come to one of our Financial Assistance Offices, you may complete Section 1 of the **Application for Financial Assistance** form and return it in the envelope provided. Applications should be filed within 90 days of discharge or point of service. The information will be used to determine if assistance is available for your hospital bill.

Mount Sinai works hard to provide high quality care and service to our community and beyond. You can be part of our efforts to provide quality care to everyone who comes through our doors by filling out the form and bringing it in to a Financial Assistance Office.

Sincerely,
Your staff at Mount Sinai Health System

Department of Financial Counseling Locations

Mount Sinai Beth Israel Medical Center Mount Sinai Beth Israel Phillips Ambulatory Care Center Mount Sinai St. Luke's Mount Sinai Roosevelt	Patient Financial Services 1111 Amsterdam Avenue at 114th Street New York, New York 10025 P: (212) 523-4674 Attn: Hiram Martinez
Mount Sinai New York Eye and Ear Infirmary	Admitting Department 310 East 14th Street New York, New York 10003 P: (212) 979-4115 Attn: Debra Hallgren
Mount Sinai Queens	Patient Financial Services 23-22 30 Road, Suite 1D Long Island City, New York 11102 P: (718) 267-4369 Attn: Thomas Weingarten
Mount Sinai Hospital REAP, Resource, Entitlement and Advocacy Program	Patient Financial Services 1 Gustave L. Levy Place, Box 6000 New York, New York 10029 P: (212) 731-3100 Attn: Erwin Ramirez