Orlin&Cohen Orthopedic Group
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REGISTRATION FORM

Instructions: Fill in the blanks and please replace any incorrect or outdated information

Patient Appointment Information						
Attending Physician	**Scheduled Resource**	**Appt Date**	**Appt Time**	**Encounter #**	**MGMRN #**	**Activity Type**

Patient Information				
Patient Name			**Preferred Name**	
DOB	**Gender**	**Marital Status**	**Marital Status Key** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Address		**City State Zip**	**Email Address**	
Cell Phone	**Preferred Language**		**Preferred Appointment Reminder Method**	
Home Phone	**Ethnicity** **Ethnicity Key** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown		**Race** **Race Key** AIA – Native American Or Alaskan ASN – Asian BAA – African American Or Black DECL – Declined NHP – Native Hawaiian Or Pacific Islander OTH – Other Or Multiracial WHT – White	
Northwell Employee – Yes or No				
Parent 1 Name – *Optional*			**Parent 2 Name – *Optional***	

Contact Information				
Contact Name	**Relationship**	**Contact Type** Emergency	**Preferred Phone**	**Alternate Phone**
Contact Name	**Relationship**	**Contact Type** Next Of Kin	**Preferred Phone**	**Alternate Phone**

Guarantor Information		
Guarantor Name:	**Guarantor DOB**	**Relationship To Patient**
Guarantor Phone	**Guarantor Address**	**City, State, Zip**

Physician Information	
Referring Physician Name	**Referring Physician Phone**
Primary Care Physician Name	**Primary Care Physician Phone**

Insurance Information			
Primary Insurance Name	**Primary Insurance ID#**	**Subscriber Name/DOB**	**Subscriber Relation To Patient**
Primary Insurance Address	**Primary Insurance Group #**		**Primary Insurance Phone #**
Secondary Insurance Name	**Secondary Insurance ID#**	**Subscriber Name/DOB**	**Subscriber Relation To Patient**
Secondary Insurance Address	**Secondary Insurance Group #**		**Secondary Insurance Phone #**

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Clinical Care Team Form

It is important for us to know the clinicians (physicians, nurse practitioners, therapists, etc.) involved in your care. Please print their contact information below.

Name: _____
Last Name First Name MI

Date of Birth: / / **Today's Date:** / /
MM/DD/YYY MM/DD/YYYY

	Provider Name	Address	Phone/Fax
Primary Care			

Specialty	Provider Name	Address	Phone/Fax

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CONSENT FOR TELEHEALTH SERVICES

Telehealth is the use of electronic information and communication technologies to remotely deliver healthcare services to patients. Please read this form for information about telehealth services and sign your name below. Your signature tells us that you have read the form and that you agree to receive treatment by telehealth.

General Information

We may use the information you provide to:

- Review your health records, images, and/or test results,
- Have a live two-way interactive audio and video communication with you, and/or
- Review output data from medical devices.

Expected benefits to you of telehealth services may include:

- Improved access to care by allowing you to remain in your home or at a doctor's office while another provider consults on your care.
- More efficient evaluation and care management.
- Obtaining expertise of a specialist, as appropriate.

Possible risks associated with telehealth services may include:

- Delays in evaluation and treatment could occur if the equipment or technology fails or if the telehealth provider decides that the transmitted information is of poor quality. If this is the case, we may need to reschedule the telehealth consult or schedule an in-person appointment with you and your provider.
- Although the electronic communication systems that we use will incorporate security protocols to protect your privacy, security protocols could fail, causing a breach of privacy of personal medical information.

In an Emergency: If you experience an emergency during a telehealth session, your telehealth provider may contact 9-1-1 or your emergency contact.

Acknowledgement and Consent

By checking the box and signing my name below, I acknowledge that I understand and agree with the following:

1. I consent to receive services via telehealth. I have the right to withhold or withdraw my consent to the use of telehealth at any time without affecting my right to future care or treatment.
2. My telehealth provider will determine whether my specific clinical needs are appropriate for care via telehealth. If my provider determines that telehealth is not appropriate for the care I need, I agree to schedule an in-person consult with my provider.
3. My medical information may be shared with others for scheduling and billing purposes and may also be communicated electronically to other providers in connection with my care. These other providers may be located in other areas, including out of state. If I am being treated for substance use disorder, an additional authorization for use of my health information will be provided to me when required by law.
4. I have been informed of all persons who will be present during the telehealth session and been given the opportunity to provide input. If I am a parent or guardian consenting to services for a minor, the patient and I have both had the opportunity to provide input regarding who can be present during a telehealth session.
5. I have the right to have staff available to me during the telehealth session for assistance if my visit is conducted in an office or hospital setting. I understand if my visit is conducted at home, the option for in person staff assistance is not available.

VD142363 (12/3/20)

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CONSENT FOR TELEHEALTH SERVICES

6. I will tell my provider where I am located at the time of my telehealth session. I have received location and license information of my telehealth provider as well as information about the staff responsible for my ongoing care.
7. The technology may fail during the telehealth session in which case either I or my provider may terminate the session. If my telehealth session is disrupted or disconnected, my provider will try to reestablish the connection or call me by phone. If we cannot reconnect, a new session will be scheduled. I agree to hold Northwell harmless for delays in evaluation or for information lost due to such technical failures.
8. If I am at home during a telehealth session, I will have access to equipment that supports the telehealth platform and have a private and safe location in which to have the session.
9. I give consent to my provider to record a telehealth session. I will not record the session without my provider's consent and under no circumstance will I record a group therapy session.
10. Alternatives to telehealth services, such as in-person services, are available to me. In choosing to participate in the telehealth services, I understand that additional services, including lab or radiology tests, may require an in-person visit. If I want a different provider, he or she may not be able to provide care via telehealth, which may necessitate an in-person visit that could delay care.
11. I am responsible for all copays and deductibles associated with the telehealth services that I receive. If I do not have insurance or if my insurance does not cover the telehealth services, I understand that I am responsible for the costs of the telehealth session.
12. If I am participating in group therapy services via telehealth, I understand and agree that (a) I must participate from a private location, (b) I will not record the telehealth session, (c) I will not invite or allow others who are not participants in the group to view or listen to the session, (d) I will maintain the confidentiality of group members and not disclose, disseminate, publish, deliver or make available to anyone outside of the group any information that may identify another group member, and (e) I must keep the ID, password and link to the virtual group session confidential. At the end of a group therapy session or if I need to leave a group therapy session early, I agree to fully and quickly logoff of the electronic communications technology platform used to conduct the services. To the extent that I violate the terms of this Section 12 or another participant's privacy in any way, I understand and acknowledge that my participation in the group therapy session may be terminated, and I may no longer be able to participate in the group therapy services via telehealth.

I have read this document carefully. I understand the risks and benefits of the telehealth services and my questions regarding the services, the technology, the costs and the terms of this consent have been answered. I give my consent to participate in the telehealth services under the terms of this Consent for Telehealth Services.

☐ **ACCEPT.** By checking the box for this "**CONSENT FOR TELEHEALTH SERVICES**" I hereby state that I have read, understood, and agree to the terms of this document.

Patient/Agent/Surrogate/Guardian* (Signature):	Date:
Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

VD142363 (12/3/20)

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CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

Consent to Treat

I authorize the medical staff, nursing staff and other personnel at this Northwell Health hospitals, Northwell Health Physician Partners ("NHPP") and associated physician locations (collectively, "Northwell',) to provide care, including telehealth services, and to administer such diagnostic, radiological and/or therapeutic procedures and treatments as the medical staff determines is necessary or advisable in my care, or, for obstetrical patients, in the care of my baby. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where indicated below. For a list of NHPP locations, please visit: https://www.northwell.edu/physician-partners/locations.

Assignment of Benefits

I hereby irrevocably assign and transfer to Northwell any monies or benefits to which I may be entitled, including benefits/monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my medical care. I authorize and direct Northwell and its physicians, having treated me, to release to such payers or other third parties who are financially responsible for my medical care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also appoint Northwell as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials and proceed against my insurance company in any action, including legal suit, on my behalf if for any reason my insurance company refuses to pay my claim. The appointment shall include all rights to recover attorney's fees and costs for such action brought by Northwell as my assignee. I further agree to provide information as necessary and to cooperate with Northwell to process and obtain payments.

Patients Entitled to Medicare Benefits

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 information about me to release it to the Social Security Administration and Centers for Medicare and Medicaid Services or its

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CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

intermediaries or carriers for the purpose of payment. I request that payment of authorized benefits related to my care be assigned to Northwell.

Guarantee of Payment

I understand that I am financially responsible for charges not covered by insurance. I agree to pay all amounts for which I am responsible for medical services rendered in accordance with the rates and terms of this practice or as determined by my health plan. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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UNDERSTANDING ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

What is an assignment of benefits?

An assignment of benefits is an arrangement where you, the beneficiary, request that your insurance company pay the health benefit payment(s) directly to your health care providers. When you sign the assignment of benefits form, you are essentially entering into a contract with your health care provider to transfer your right of reimbursement from your insurance company to your health care provider. This provides a convenience to both you and your health care provider.

How does this benefit me, the patient?

This arrangement benefits you as a patient because you don't have to pay your health care provider(s), send the bill to your insurance company, and then wait for payment.

What information will be disclosed to my insurance carrier?

In order to process payment for your treatment, your insurance carrier will need certain patient information acquired during the course of your treatment, including, but not limited to any medical records, notes, test results, x-rays, MRI reports, including itemization of any charges and payments on your account.

What if I do not sign the assignment of benefits form?

If you do not sign the assignment of benefits, your health care provider will ask you to pay them directly and you will have to seek reimbursement from your insurance company. If your insurance company denies all or part of your medical bill, you will be responsible for disputing your medical bills. This may include filing an appeal and a review process.

What does guarantee of payment mean?

This means that you are responsible for all payment obligations arising out of your treatment or care. This includes any deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier directly.

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UNDERSTANDING ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

Deductible: The amount you pay for your healthcare services (excluding monthly premiums) before your health insurance begins to pay. For example, if your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your health care services. After you reach $2,000, your health insurance will cover the rest of the cost.

Co-Payment: A fixed amount (for example, $20) you pay to your healthcare provider at the time you receive services. You may have to pay a co-pay for each covered visit to your provider, depending on your plan. The amount can vary by the type of covered health care service.

Co-Insurance: A percent you must pay after you have paid your deductible. This payment is for covered services only. You may still have a co-pay. For example, your plan might cover 80% of your medical bill. You will have to pay the other 20%. The 20% is the co-insurance.

Supplemental Insurance: An additional insurance plan that helps pay for health care costs that are not covered by a person's regular health insurance plan. These costs include copayments, coinsurance and deductibles. There are many different types of supplemental health insurance, including vision, dental, hospital, accident, disability, long-term care and Medicare supplemental plans.

VD141072 (6/14/21)

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Consent to Unencrypted E-mail and Text Communications

(This consent is not for the release of medical records. Please see VD001)

I consent to communicate with Northwell Health through unencrypted e-mail and/or text messaging. If I am signing this document for another person, I agree that I am consenting for this patient and I will provide the relationship (legal representative) where indicated below. By signing this document, I agree that:

1. Most personal e-mail and text message services do not encrypt or otherwise protect electronic communications. Therefore, there is a risk that e-mails I send from my e-mail account and texts I send from my phone/computer to my provider may be accessed by others not affiliated with my provider while in transit or upon receipt. As a result, I understand that if I communicate with my provider using my personal e-mail or text account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to send my protected health information via e-mail and text messages in designated circumstances. I further acknowledge that e-mails and text messages may be subject to technical malfunctions. Therefore, I understand that e-mail and text message delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.
2. Text messaging will be used only for the purpose of providing me with portal invitations, identity authentication and appointment related information, including limited information about visit preparation and the services that I receive. Text messaging may not be used to communicate with my healthcare provider for other purposes including other information related to my care.
3. Email and text message communications should not be used for emergencies or for communicating time-sensitive/urgent information. E-mail communication may be only processed during routine business hours. In the event of a medical emergency, I should call 911 or go to the nearest Emergency Department.
4. Any electronic communication between my provider and me regarding my care may become part of my medical record.
5. I accept that my healthcare provider or I can terminate electronic communications at any time.
6. I am responsible for notifying the healthcare provider if I choose to discontinue electronic communications or if my contact information has changed. The contact information used for the purposes stated in this form will be the most current information on file with Northwell Health.

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Consent to Unencrypted E-mail and Text Communications

Northwell Health strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail and limited text communications, as described above, unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. By signing below and authorizing unencrypted electronic communications, I acknowledge the risks to which my information may be exposed.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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OUTPATIENT CONTACT CONSENT FORM

Email, Text Messages, and Voicemail

It is important for Northwell Health to be able to communicate with you about your healthcare. By providing an email address or phone number, you agree that Northwell Health, its contractors and their subcontractors may use those means of communication, including autodialed phone calls*, autodialed text messages, and voicemails, for purposes of communicating about your healthcare, including appointment related information, providing portal invitations, health reminders, identity authentication, prescription information, test results, and information about billing and payment for the medical services you receive. Message and data rates may apply to text messages, and not all carriers are covered. You can always text STOP to stop (a confirmation message will be sent) or HELP for help.

Messages sent through email or SMS text will be limited in the information they contain to protect your privacy. These text messages and emails are not encrypted in transit and may be accessed by others not affiliated with Northwell Health while in transit or upon receipt. To reduce the chance that your information is seen by the wrong recipient, we suggest you enable the highest security measures on your personal devices (passcodes, strong passwords, two step authentication, etc.)

Methods of communication:
If you DO NOT want Northwell to communicate with you via the email or phone number you provided, please initial below. **Please note:** If you opt out of communication below, you may still receive information necessary to access or prepare for in-person or virtual appointments (such as links to health visits), as well as specific communications you request.

☐ DO NOT email me ☐ DO NOT text me

☐ DO NOT leave a voice mail message for me

It is important for you to keep your contact information with Northwell Health up to date and review your email and phone numbers at each visit. **If you have previously opted out of e-mail, text messages and/or voicemails and express a change in your preferences on this form at this visit, you have opted back into all future e-mail, text and/or voicemail communications.**

*This includes autodialed phone calls to landlines and cell phones.

VD145430 (02/17/2022)

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OUTPATIENT CONTACT CONSENT FORM

My Care Contacts

☐ Check here if you do not wish for us to speak with anyone but you.

If you would like to authorize Northwell Health to communicate with other individuals about your healthcare, please indicate your communication preferences below. The care contacts below are not applicable in NYS Office of Mental Health (OMH) – licensed programs. I give Northwell Health consent to communicate with the following individual(s) about my healthcare (such as appointment details, prescription information, test results, billing and payment).

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

VD145430 (02/17/2022)

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OUTPATIENT CONTACT CONSENT FORM

Acknowledgement

By signing below, I understand that Northwell Health has my permission to contact me or my Care Contact(s) identified on this form in the manner described herein. I understand that I am responsible for notifying the office staff if there are changes to my designated communication preferences. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where specified below.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

VD145430 (02/17/2022)

Northwell Health®

Authorization for Access to Patient Information - Healthix

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 Northwell Health (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 and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

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 Northwell Health to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for Northwell Health to access my electronic health information through Healthix.

☐ **3. I DENY CONSENT** for Northwell Health to access my electronic health information through Healthix for any purpose, ***even*** *in a medical emergency.*

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.

Patient/Agent/Relative/Guardian* (Signature) Date / Time

Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date / Time

Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time

Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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Authorization for Access to Patient Information - Healthix

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(s) 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 & diagnoses
   - Birth control and abortion (family planning)
   - Medication and Dosages
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Diagnostic information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
   - Trauma history summary

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 checking 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 Provider Organization at: 800-894-3226; 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**.**

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Pharmacy Intake Form

Patient Name:_____ Date of Birth: _____

Retail Pharmacy Information *(please complete as much information as possible)*

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone Number: _____

Pharmacy Fax Number: _____

Do you use a Mail Order Pharmacy? *(Circle One)* Yes No

Mail Order Name: _____

Mail Order Address: _____

Mail Order Telephone Number: _____

Mail Order Fax Number: _____

Do you use a pharmacy in addition to the above? *(Circle One)* Yes No

This pharmacy is: ☐ Seasonal ☐ Specialty ☐ Other _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone Number: _____

Pharmacy Fax Number: _____

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REGISTRATION FORM - SUPPLEMENTAL INFORMATION

Legal Name: _____ **Date of Birth:** _____

MGMRN #: _____ **Today's date:** _____

Northwell Health is dedicated to providing leading edge care and world-class resources that meet the needs of all of our patients. We strive to break down barriers and offer individualized, compassionate health care to each and every person. The following questions allow us to serve and promote the personal health and wellness of all of our patients.

Gender: What gender appears on your legal identification? Currently: _____

- ☐ Female
- ☐ Male

Birth Sex: What sex appears on your original birth certificate?

- ☐ Female
- ☐ Male
- ☐ Other/Intersex
- ☐ Withheld/Decline to Answer

☐ Same as Above

Gender Identity: What is your current gender identity?

- ☐ Female
- ☐ Male
- ☐ Non-binary/GNC/Genderqueer
- ☐ Transfemale/Male to Female
- ☐ Transmale/Female to Male
- ☐ Various/Other: _____
- ☐ Withheld/Decline to Answer

☐ Same as Above

Please complete the following optional questions:

Name you prefer to identify with:

_____

(last name) (first name) (middle name)

Preferred Pronoun: Which pronoun should we use to refer to you?

- ☐ Her/She
- ☐ Him/He
- ☐ Them/They
- ☐ Various/Other: _____
- ☐ Withheld/Decline to Answer

☐ No Changes

VD-AFC-1011 (5/27/21)

Northwell Health®

Acknowledgement of Receipt

ADDRESSOGRAPH

I have received a copy of the Provider's Notice of Privacy Practices.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient

Telephonic Interpreter's ID #	Date	Time)

OR

Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature)	Date	Time	Print Witness Name

PROVIDER USE ONLY

_____ Patient or patient representative refused to sign/accept Notice of Privacy Practices

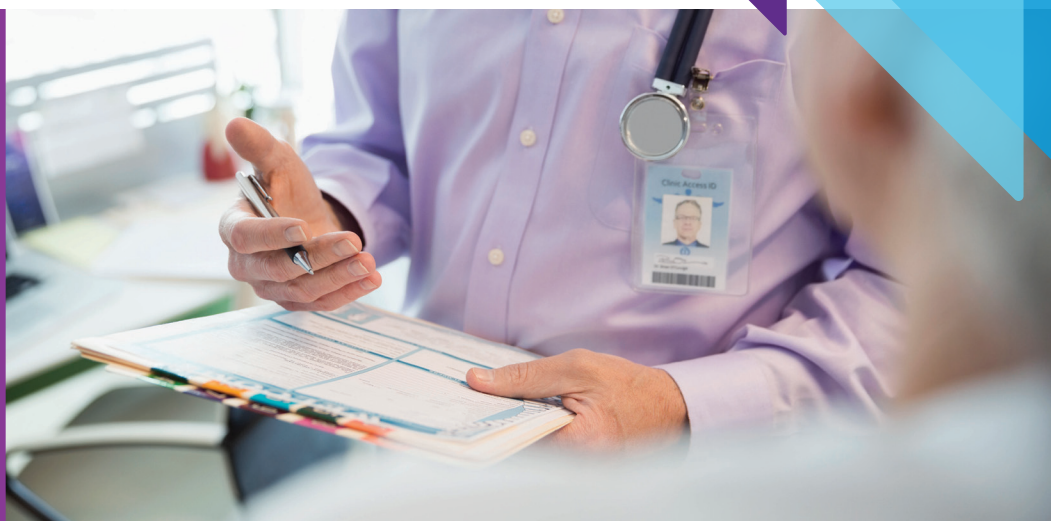
_____ Patient unable to sign

Telephonic Interpreter's ID #	Date	Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Effective date: September 1, 2016

Notice of Privacy Practices



This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

What is the Notice of Privacy Practices?

The Notice explains how we fulfill our commitment to respect the privacy and confidentiality of your protected health information. This Notice explains how we may use and share your protected health information, as well as the legal obligations we have regarding your protected health information, and about your rights under federal and state laws. The Notice applies to all records held by the Northwell Health facilities and programs listed at the end of this Notice, regardless of whether the record is written, computerized or in any other form. We are required by law to make sure that information that identifies you is kept private and to make this Notice available to you. In this Notice, the term "protected health information" refers to individually identifiable information about you, which may include:

- Information about your health condition (such as medical conditions and test results you may have)
- Information about healthcare services you have received or may receive in the future (such as a surgical procedure)
- Information about your healthcare benefits under an insurance plan (such as whether a prescription is covered)
- Geographic information (such as where you live or work)
- Demographic information (such as your race, gender, ethnicity or marital status)
- Unique numbers that may identify you (such as your Social Security number, your phone number or your driver's license)
- Biometric identifiers (such as fingerprints)
- Full-face photographs

Northwell Health®

Who follows the Northwell Health Notice of Privacy Practices

This Notice describes the practices of Northwell Health (collectively referred to as "we" or "us"). The privacy practices described in this Notice will be followed by all healthcare professionals, employees, medical staff, trainees, students, volunteers and business associates of the Northwell Health organizations specified at the end of this Notice.

Overview

The following is a summary of the key provisions in our Notice. This summary is not a complete listing of how we use and disclose your protected health information. If you have any questions about any of the information contained in this summary, please read this full Notice of Privacy Practices or contact a Northwell Health staff member for more information.

Northwell Health may use and disclose your protected health information without your consent to:

- Provide you with medical treatment and other services
- Carry out certain operations necessary to the operation of our facilities and programs, such as quality improvement studies, medical education and verifying the qualifications of doctors
- Coordinate your care, which may include such things as giving you appointment reminders and telling you about other treatment options available through Northwell Health
- Talk to family or friends involved in your care, unless otherwise indicated by you
- Ensure that we follow the rules of regulatory agencies regarding the quality of care we provide
- Comply with all legal requirements, subpoenas and court orders
- Engage in certain preapproved research activities
- Request payment from you, your insurance company or some other third-party payer
- Include information in our hospital directory, such as name and room number, for the benefit of visitors or members of the clergy
- Contact you for fundraising activities unless otherwise indicated by you
- Meet special situations as described in this Notice, such as public health and safety

You have a right to:

- See and obtain a copy of your medical record in the format of your choosing, with certain restrictions
- Ask us to amend the protected health information we have about you if you feel the information we have is wrong or incomplete
- Ask us to restrict or limit the protected health information we use and share about you
- Ask us to communicate with you about medical matters in a certain way or at a specific location
- Obtain a list of individuals or entities that have received your protected health information from Northwell Health, subject to limits permitted by law
- Be notified if your protected health information is improperly disclosed or accessed
- Obtain a paper copy of this Notice
- Submit a complaint

How we may use and share your protected health information with others

The following categories describe different ways that we may use and disclose your protected health information. Not every use or disclosure will be listed; however, all the ways we are permitted to use and disclose your information will fall within at least one of the following categories:

For treatment: We may use or disclose protected health information about you to provide, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, students or other Northwell Health personnel involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the hospital's food service if you have diabetes so that we can arrange for appropriate meals. We may share protected health information about you with non-Northwell Health health providers, agencies or facilities in order to provide or coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose your protected health information to people outside Northwell Health who may be involved in your continuing medical treatment after you leave our care, such as other healthcare providers, home health agencies and transport companies.

For payment: In order to receive payment for the services we provide to you, we may use and share your protected health information with your insurance company or a third party, such as Medicare and Medicaid. We may also share your protected health information with another doctor, facility or service provider, such as an ambulance company or subcontractor within our facilities that has treated you or has provided services to you, so that they can bill you, your insurance company or a third party. For example, in order for your insurance company to pay for your health-related services at Northwell Health, we must submit a bill that identifies you, your diagnosis and the treatment we provided. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment. In addition, insurance companies and other third parties may require that we provide your Social Security number for verification and payment purposes.

For healthcare operations: We may use your protected health information to support our business activities and improve the quality of care. For example, we may use your protected health information to review the treatment and services that we gave you and to see how well our staff cared for you. We may share your information with our students, trainees and staff for review and learning purposes. Your protected health information may also be used or disclosed for accreditation purposes, to handle patients' grievances or lawsuits and for health care contracting relating to our operations.

Appointment reminders: We may use and share your protected health information to remind you of your appointment for treatment or medical care. For example, if your doctor has sent you for a test, the testing site may call you to remind you of the date you are scheduled.

Hospital directory: If you are admitted to the hospital, your name, room location, general condition (such as fair or stable) and religious affiliation may be listed in the hospital's patient directory. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. Unless you object, we will include this limited information about you in the directory while you are a patient. Your room location and general condition will be released to people who ask for you by name. Your religious affiliation will be given only to a member of the clergy, such as a priest, minister or rabbi, even if they do not ask for you by name. If you object to being included in the hospital directory, we will not disclose your information to anyone who asks for you unless required by law. If you do not want your information listed in the hospital directory, you must notify personnel during registration or tell your caregivers after you have been admitted to the hospital.

Business associates: We may share your protected health information with a business associate that we hire to help us, such as a billing or computer company or transcription service. Business associates will have assured us in writing that they will safeguard your protected health information as required by law.

Treatment options and other health-related benefits and services: We may use your information to contact you about treatment options and other health-related benefits and services provided by Northwell Health that may be of interest to you. This may include information about our staff or about health-related products and services offered by Northwell Health that may be beneficial for you. However, we will not use your information to engage in marketing activities (other than face-to-face communications) without your written authorization. We also will never sell your protected health information to third parties without your written authorization to do so. However, we may receive payment to disclose your protected health information for certain limited purposes permitted by law.

Fundraising activities: We may contact you to provide information about Northwell Health sponsored activities, including fundraising programs and events. We may use your protected health information, such as the department where you were seen or the name of the physician you saw, in order to contact you to ask you to make a charitable contribution to support research, teaching or patient care at Northwell Health related to your specific treatment. If you do not want to be contacted about our fundraising opportunities and events, you can let us know at any time by calling (855) 621-2844 and we will no longer reach out to you. Please give your name and address so that we may suppress your name from all future fundraising.

Individuals involved in your care or payment for your care: Unless you decline, we may release protected health information to people such as family members, relatives or close personal friends who are helping to care for you or pay your medical bills. Additionally, we may disclose information to a patient representative. If a person has the authority under the law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your protected health information. Parents and legal guardians are generally patient representatives for minors unless the minors are permitted by law to act on their own behalf and make their own medical decisions in certain circumstances. If you do not want protected health information about you released to those involved in your care, please notify us.

Disaster relief efforts: We may disclose your protected health information to an organization such as the American Red Cross so that your family can be notified about your condition, status and location in the event of a disaster. If we can reasonably do so while trying to respond to the emergency, we will try to obtain your permission to share this information first.

Research: Northwell Health conducts research to advance science both to prevent disease and to cure patients. All research projects conducted by Northwell Health must be approved through a special review process to protect patient safety, welfare and confidentiality. Your protected health information may be important to research efforts and may be used for research purposes in accordance with state and federal law.

Researchers may contact you regarding your interest in participating in certain research studies after receiving your authorization or approval of the contact from a special review board called an Institutional Review Board (IRB). An IRB is a special committee that protects the rights and welfare of people who participate in research studies. Enrollment in most studies may occur only after you have been informed about the study, had an opportunity to ask questions and indicated your willingness to participate by signing an authorization or consent form that has been reviewed and approved by an IRB. In some instances, federal law allows us to use your protected health information for research without your authorization, provided we get approval from an IRB or other special review board. These studies will not affect your treatment or welfare, and your private health information will continue to be protected. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment. Federal law also allows researchers to look at your protected health information when preparing future research studies, so long as any information identifying you does not leave a Northwell Health facility. If you have any questions about how your medical record information could be used in a research protocol, please call the Northwell Health Office for Human Research Protections at (516) 719-3101.

As required by law: We will share your protected health information when federal, state or local law requires us to do so. This includes to the Secretary of the U.S. Department of Health and Human Services for HIPAA rules compliance and enforcement purposes.

Special situations

Legal proceedings, lawsuits and other legal actions: We may share your protected health information with courts, attorneys and court employees when we get a court order, subpoena, discovery request, warrant, summons or other lawful instructions from those courts or public bodies, and in the course of certain other lawful, judicial or administrative proceedings, or to defend ourselves against a lawsuit brought against us.

Law enforcement: If asked to do so by law enforcement, and as authorized or required by law, we may release protected health information:

- To identify or locate a suspect, fugitive, material witness or missing person
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death suspected to be the result of criminal conduct
- About criminal conduct at Northwell Health

To avert a serious threat to health or safety: We may use and disclose your protected health information when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help stop or reduce the threat.

Public health risks: As required by law, we may disclose your protected health information to public health authorities for purposes related to: preventing or controlling disease, injuries or disability; reporting vital events, such as births and deaths; reporting child abuse or neglect; reporting domestic violence; reporting reactions to medications or problems with products; notifying people of recalls, repairs or replacements of products they may be using; notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease and reporting to your employer findings concerning work-related illness or injury so that your workplace may be monitored for safety.

Workers' compensation: We may share your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Specialized government functions: If you are a member of the armed forces (of either the United States or of a foreign government), we may share your protected health information with military authorities so they may carry out their duties under the law. We may also disclose your protected health information if it relates to national security and intelligence activities, or to providing protective services for the President or for other important officials, such as foreign heads of state.

Health oversight activities: We may disclose your protected health information to local, state or federal governmental authorities responsible for the oversight of medical matters as authorized by law. This includes licensing, auditing and accrediting agencies and agencies that administer public health programs such as Medicare and Medicaid.

Coroners, medical examiners and funeral directors: We may release your protected health information to a coroner or medical examiner as necessary to identify a deceased person or to determine the cause of death. We also may release protected health information to funeral directors so they can carry out their duties.

Organ, eye and tissue donation: If you are an organ donor, we may release your protected health information to organizations that obtain organs or handle organ, eye or tissue transplantation. We also may release your information to an organ donation bank as necessary to facilitate organ, eye or tissue donation and transplantation.

Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law officer as authorized or required by law. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Incidental disclosures: While we will take reasonable steps to safeguard the privacy of your protected health information, certain disclosures of your information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your information. For example, during the course of a treatment session, other patients in the treatment area may see or overhear discussion of your information. These "incidental disclosures" are permissible.

Uses and disclosures requiring your written authorization

Uses and disclosures not covered in this Notice: Other uses and disclosures of your protected health information not described above in this Notice or permitted by law will be made only with your written authorization. In addition, we will obtain your authorization for most uses and disclosures of psychotherapy notes. When consent for disclosure is required by law, your consent will be obtained prior to such disclosure. If you give us authorization to use or share protected health information about you, you may revoke that authorization in writing at any time. Please understand that we are unable to retract any disclosures already made with your authorization.

Stricter state laws: New York has adopted medical privacy laws that are stricter than federal law. For example, New York prohibits the disclosure of HIV-related information and the records of licensed mental health facilities for certain purposes that are permitted by HIPAA. We will follow these stricter state laws, and we will not disclose your protected health information for any purpose prohibited by these laws without your consent.

Your rights concerning your protected health information

Right to ask to see and obtain a copy: You have the right to ask to see and obtain a copy of the protected health information we used to make decisions about your care. This includes medical records (including laboratory testing results) and billing records, but does not include psychotherapy notes. If the record is maintained electronically by Northwell Health, you have the right to obtain an electronic copy of the record. Your request must be in writing and must be given to the Health Information Management Correspondence Unit. If you are requesting laboratory testing results directly from your laboratory, your request must be in writing and must be given to the laboratory. We may charge you a reasonable fee for the costs of copying, mailing or other expenses associated with complying with your request. We may deny access under certain limited circumstances. If we deny your request, we may provide you a written summary of your record or we may provide you with limited portions of your record. If we deny your request, in part or in its entirety, you may request that the denial be reviewed. A description of the process to have a denial reviewed, as well as information on how to file a complaint with the Secretary of the U.S. Department of Health and Human Services, will be included in the correspondence informing you of our decision to deny your request.

Right to ask for an amendment or addendum: If you feel that the protected health information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment as long as the information is kept by or for Northwell Health. You are required to submit this request in writing by completing a Request for Amendment to Health Information form. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the protected health information kept by or for Northwell Health
- Is not part of the information you would be permitted to see and copy
- Is determined by us to be accurate and complete

If we deny your request, we will give you a written explanation of why we did not make the amendment. You will have the opportunity to have certain information related to your request included in your medical records, such as your disagreement with our decision. We will also provide you with information on how to file a complaint with Northwell Health or with the U.S. Department of Health and Human Services.

Right to ask for an accounting of disclosures: You have the right to ask us for a listing of those individuals or entities who have received your protected health information from Northwell Health in the six years prior to your request. This listing will not cover disclosures made:

- To you or your personal representative
- To provide or arrange for your care
- To carry out treatment, payment or healthcare operations
- Incident to a permitted use or disclosure
- To parties you authorize to receive your protected health information
- To those who request your information through the
- hospital directory
- To your family members, relatives or friends who are involved in your care
- For national security or intelligence services
- To correctional institutions or law enforcement officials
- As part of a limited data set for research purposes

You must submit your request in writing to the Office of Corporate Compliance at 1111 Marcus Avenue, Suite 107, New Hyde Park, NY 11042. Your request must state the time period for the requested disclosures. The first list requested within a 12-month period will be free. We may charge you for responding to any additional requests in that same period.

Right to request restrictions: You have the right to ask us to restrict or limit the protected health information we use or disclose about you for treatment, payment or healthcare operations. In most cases, we must consider your request, but we are not required to agree to it. However, we must agree to limit disclosures made to your health insurer or other third-party payer about services we provided to you if, prior to receiving the medical services, you pay for the services in full, unless the disclosure of that information is required by law. If multiple medical services are provided to you at one time by Northwell Health, you will have to pay for all of the services in order to restrict the disclosure of any one of them to your health insurance. If you require follow-up care related to the undisclosed service and you decide you do not want to pay for that follow-up care at the time it is provided to you, it may be necessary for us to tell your health insurer about the previously undisclosed service. This will be done only to the extent necessary to receive payment for subsequent medical treatment. To restrict information provided to your health insurer or to another third-party payer, you must notify a Northwell Health staff member at the time of registration and fill out a form indicating this preference. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or a friend. For example, you could ask that we not disclose information to a family member about a surgery you had. Your request for any restriction must be made in writing and given to the Office of Corporate Compliance at 1111 Marcus Avenue, Suite 107, New Hyde Park, NY 11042.

Right to request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at home or only by mail. If you want us to communicate with you in a special way, you will need to give us details about how to contact you, including a valid alternate address. You will also need to give us information about where your bills may be sent. Your request must be made in writing by filling out a Northwell Health form requesting confidential communications. As indicated on the form, this request must be sent to the Office of Corporate Compliance at 1111 Marcus Avenue, Suite 107, New Hyde Park, NY 11042. You do not need to provide a reason for your request. We will comply with all reasonable requests. However, if we are unable to contact you using the requested means or locations, we may contact you using whatever information we have.

Right to receive notice of a breach: You have a right to be notified in the event of a breach of the privacy of your unsecured protected health information by Northwell Health or its business associates. You will be notified as soon as reasonably possible, but no later than 60 days following our discovery of the breach. The notice will provide you with the date we discovered the breach, a brief description of the type of information that was involved and the steps we are taking to investigate and mitigate the situation, as well as contact information for you to ask questions and obtain additional information.

Right to a paper copy of this Notice: Upon request, you may at any time obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically. To request a copy, please contact the Office of Corporate Compliance at (800) 894-3226 or ask the registrar/receptionist for one at the time of your next visit.

How to file a privacy complaint: If you believe that your privacy rights have not been followed as directed by federal regulations and state law or as explained in this Notice, you may contact us by telephone, submit a written complaint through our web-based reporting, or file a written complaint with us at the address below:

Corporate Compliance Privacy Officer
1111 Marcus Avenue, Suite 107, New Hyde Park, NY 11042
Compliance Helpline: (800) 894-3226
Web-based reporting: Northwell.ethicspoint.com

You will not be retaliated against or denied any health services if you file a complaint: If you are not satisfied with our response to your privacy complaint or you otherwise wish to file a complaint, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The complaint must be in writing, it must describe the subject matter of the complaint and the individuals or organization that you believe violated your privacy and it must be filed within 180 days of when you knew or should have known that the violation occurred. The complaint should then be sent to:

Region II: New York
Att: Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312 New York, NY 10278
Phone: (800) 368-1019 | Fax: (202) 619-3818 | TDD: (800) 537-7697

Future changes to Northwell Health's privacy practices and this Notice

We reserve the right to change this Notice and the privacy practices of the organizations covered by this Notice without first notifying you. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you as well as any information we receive in the future. To request a copy of the most recent Notice, please contact Northwell Health's Office of Corporate Compliance at (800) 894-3226 or ask the registrar/receptionist for one at the time of your next visit. The current Notice will also be posted to the Northwell Health website, Northwell.edu. At any time, you may request a copy of the Notice currently in effect.

All Northwell Health facilities that provide care to the public will follow this Notice. These facilities include, but are not limited to:

Broadlawn Manor Nursing & Rehab Center[1]
Brooklyn Ambulatory Care, P.C.
Carnegie Cardiovascular, P.C.
Central Suffolk Hospital (d/b/a Peconic Bay Medical Center)
Chaps Community Health Center Inc.
CLNY Alliance, Inc.
Concorde Medical Group formally known as Marcus Avenue Medical, P.C.
Formativ Health, LLC
Glen Cove Hospital
Greenwich Village Ambulatory Surgery Center, LLC
Harbor View Medical Services, P.C.
Hospice Care in Westchester and Putnam, Inc.
Hospice Care Network
Huntington Hospital Association
Huntington Hospital Dolan Family Health Center, Inc.
Island Diagnostic Laboratories, Inc.
John T. Mather Memorial Hospital
Lakeville Surgery, P.C.
Lenox Health Greenwich Village[2]
Lenox Hill Cardiology Associates, P.C.
Lenox Hill Hospital
Lenox Hill Hospital Medical, P.C.
Lenox Hill Interventional Cardiac & Vascular Services, P.C.
Lenox Hill Pathology, P.C.
Lenox Otolaryngology, Head & Neck Surgery, P.C.
Long Island Jewish Forest Hills[3]
Long Island Jewish Medical Center
Long Island Jewish Valley Stream[3]
Long Island Jewish Medical Center at Home Pharmacy, Inc.
Manhattan Eye, Ear & Throat Hospital (MEETH)[2]
Manhattan Minimally Invasive and Bariatric Surgery, P.C.

Marcus Avenue Medical, P.C. (d/b/a Concorde Medical Group)
Medical Care of Queens, PC (d/b/a Queens Medical Associates)
North Shore Cardiovascular & Thoracic Surgery, P.C.
North Shore Radiology at Glen Cove, P.C.
North Shore University Hospital
North Shore-LIJ and Yale New Haven Health Medical Air Transport, LLC
North Shore-LIJ Anesthesiology, P.C.
North Shore-LIJ Cardiology at Deer Park, P.C.
North Shore-LIJ Heart Surgery, P.C.
North Shore-LIJ Internal Medicine at Lynbrook, P.C.
North Shore-LIJ Internal Medicine at New Hyde Park, P.C.
North Shore-LIJ Internal Medicine, P.C.
North Shore-LIJ Medical Group at Huntington, P.C.
North Shore-LIJ Medical Group at North Nassau, P.C.
North Shore-LIJ Medical Group at Syosset, P.C.
North Shore-LIJ Medical Group Urgent Medical Care, P.C.
North Shore-LIJ Medical Group, P.C.
North Shore-LIJ Medical, P.C.
North Shore-LIJ OB-GYN at Garden City, P.C.
North Shore-LIJ Ob-Gyn at New Hyde Park, P.C.
North Shore-LIJ Ob-Gyn, P.C.
North Shore-LIJ Occupational Medicine, P.C.
North Shore-LIJ Orzac Center for Rehabilitation[3]
North Shore-LIJ Pediatrics of Suffolk County, P.C.
North Shore-LIJ Radiology Services, P.C.
North Shore-LIJ Urgent Care, P.C.
Northern Westchester ASC, LLC
Northern Westchester Hospital Association (d/b/a Northern Westchester Hospital)
Northwell Health Laboratories, Inc.
Northwell Health Stern Family Center for Rehabilitation
Northwell Healthcare, Inc.
Northwell Proton Therapy, P.C.
Park Lenox Emergency Medicine, P.C.
Park Lenox Medical, P.C.
Park Lenox OB/GYN, P.C.
Park Lenox Orthopaedics, P.C.
Park Lenox Pediatric, P.C.
Park Lenox Surgical, P.C.
Peconic Bay Primary Medical Care, P.C.
Phelps Medical Services, P.C.
Phelps Memorial Hospital Association (d/b/a Phelps Hospital)
Physicians of University Hospital, P.C.
Plainview Hospital
Prime Care Medical of Long Island, P.C.
RegionCare, Inc.
South Oaks Hospital[1]
South Shore Surgery Center, LLC
South Shore University Hospital
Sports Physical Medicine and Rehabilitation Services of the North Shore Long Island Jewish Health System, P.C.
Sports Physical Therapy, Occupational Therapy and Rehabilitation Services of North Shore, P.L.L.C.
SSH Inc.
Staten Island Imaging Corp.
Staten Island Neonatology, P.C.
Staten Island University Hospital – North[4]
Staten Island University Hospital – South[4]
Staten Island University Hospital Perinatology, P.C.
Steven and Alexandra Cohen Children's Medical Center of New York[3]
Syosset Hospital[5]
The Feinstein Institute for Medical Research
The Heart Institute
The Long Island Home
True North Dialysis Center, LLC
True North Medical Group, P.C.
True North Medical Group, P.C. (d/b/a Healthcare Associates in Medicine, a Division of Orlin & Cohen)
True North Medical Group, P.C. (d/b/a Orlin & Cohen Medical Specialist Group)
United Medical Surgical, P.C.
University Physicians Oncology/Hematology Group, P.C.
Virtual North, P.C.
VNA Home Health Services, Inc.
Wellbridge Psychiatry, P.C.
Westchester Health Medical, P.C.
Yorktown Imaging, LLC
Zucker Hillside Hospital[3]

[1]Indicates a facility that is a division of the Long Island Home.

[2]Indicates a facility that is a division of Lenox Hill Hospital.

[3]Indicates a facility that is a division of Long Island Jewish Medical Center.

[4]Indicates a facility that is a division of Staten Island University Hospital.

[5]Indicates a facility that is a division of North Shore University Hospital.