

WELCOME TO...

*Dr. Ratner's Office
407 Franklin Avenue
Franklin Square, New York 11010*

FOR OFFICE USE ONLY: **CHART #** _____ **SOF/LOR:** _____

TODAY'S DATE: _____ **REFERRED BY:** _____

WHO IS YOUR primary care physician (PCP)? _____

~~~~~  
*Last Name:* \_\_\_\_\_ *First Name:* \_\_\_\_\_ *Middle Initial:* \_\_\_\_\_

*Street Address:* \_\_\_\_\_

*City:* \_\_\_\_\_ *State:* \_\_\_\_\_ *Zip Code:* \_\_\_\_\_

*Male*    *Female*      *Date of Birth:* \_\_\_\_\_      *Social Security #:* \_\_\_\_\_

*Home Telephone #:* \_\_\_\_\_      *Work Telephone #:* \_\_\_\_\_

*Employer or School:* \_\_\_\_\_

*Marital Status:*   *SINGLE:* \_\_\_ *MARRIED:* \_\_\_ *OTHER:* \_\_\_      **IN CASE OF AN EMERGENCY - CONTACT NAME & TELEPHONE #:** \_\_\_\_\_

~~INSURANCE INFORMATION~~

**PRIMARY Insurance Company:** \_\_\_\_\_

*Address:* \_\_\_\_\_ *Policy #:* \_\_\_\_\_

*Group #:* \_\_\_\_\_ *Policy Holder's Name:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Policy Holder's DOB:* \_\_\_\_\_ *Employer:* \_\_\_\_\_ *Local/Union:* \_\_\_\_\_

**SECONDARY Insurance Company:** \_\_\_\_\_

*Address:* \_\_\_\_\_ *Policy #:* \_\_\_\_\_

*Group #:* \_\_\_\_\_ *Policy Holder's Name:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Policy Holder's DOB:* \_\_\_\_\_ *Employer:* \_\_\_\_\_ *Local/Union:* \_\_\_\_\_

*Please complete our financial / authorization form (on reverse side).*

Thank You.

*Scott J. Ratner, M.D., F.A.C.C., P.C.  
407 Franklin Avenue  
Franklin Square, NY 11010*

## **Authorization Form**

**AUTHORIZATION TO PAY:** *I authorize that payment of medical benefits be made on my behalf to Scott J. Ratner, M.D., F.A.C.C., P.C. for any service(s) rendered.*

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** *I authorize any holder of medical information, regarding me, to release said information to my insurance company and it's agents.*

**MANAGED CARE RESPONSIBILITY:** *Scott J. Ratner, M.D., F.A.C.C., P.C. has informed me that I am responsible for requesting any referral needed from my Primary Care Physician (PCP). I understand that I must notify the staff Scott J. Ratner, M.D., F.A.C.C., P.C. to get me an authorization or referral for the following:*

- **Dr. Ratner wants me to see a specialist.**
- **Follow up visits with a specialist.**
- **Emergency Room visits.**
- **Hospital admissions.**
- **Any surgery/procedure requiring authorization by my insurance plan.**

*I understand that payment is due when services are rendered unless prior arrangements are made. Scott J. Ratner, M.D., F.A.C.C., P.C. will act as an agent in helping me obtain reimbursement from my insurance company.*

*I permit a copy of this authorization to be used in place of the original.*

*This authorization will remain in force until termination is requested in writing by the enrollee.*

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*Patient's Signature*

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*Parent's Signature if Patient is a Minor*

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*Today's Date*

SCOTT J. RATNER, M.D., F.A.C.C.

407 FRANKLIN AVENUE  
FRANKLIN SQUARE, NEW YORK 11010  
(516) 616-0808

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date \_\_\_\_\_ Initials \_\_\_\_\_

Reason: \_\_\_\_\_

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**SCOTT J. RATNER,  
M.D., FACC**

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# 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 carefully. If you have any questions about this notice please contact our Privacy Officer, Connie Papandrew.

**407 Franklin Avenue  
Franklin Square, NY 11010  
(516) 616-0808  
Fax (516) 616-0998**

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised copy in the mail or by asking for one at the time of your next appointment.

**1. Uses and Disclosures of Protected Health Information Without Your Written Authorization. Treatment:** We will use and disclose your protected health information to provide or manage your health care and related services. This includes the coordination or management of our health care with a third party that has already obtained your permission to have access to your protected health care information. We will also disclose protected health information to other physicians that may be treating you. For example, your protected health information may be provided to a physician whom you have been referred to, to ensure that the physician has the necessary information to diagnose or to treat you. In addition, we may disclose your protected health information to another physician or health care provider (e.g., specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

**Payment:** Your protected health information may be used to obtain payment for your health care services. This includes certain activities that your health insurance plan may undertake before it approves or pays for health care services we recommend, such as making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessary, and undertaking utilization reviewing activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical student. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We shall share your protected health information with third party business associates for purposes of billing, transcription services, etc. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, a written contract that contains terms that will protect the privacy of your protected health information will be constructed.

**2. Other permitted and required use disclosures that may be made unless you object to such uses or disclosures.** You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician will use professional judgment to determine if the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others involved in your health care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary. If we determine that it is in your best interest based on our professional judgment, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate care with family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as possible after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent, he or she may still use or disclose your protected health information to treat you in an emergency situation.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you, but is unable to, due to substantial communication barriers.

**3. Other permitted and required use disclosures that may be made without your authorization to comply with legal mandates.**

We may use or disclose your protected health information if required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and public health authorities that are permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law; audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, government regulatory programs and civil right enforcement agencies.

**Abuse or Neglect:** We are required by law to report suspicions of elder abuse, domestic violence, child abuse or neglect to a governmental entity or agency authorized to receive such information. In each case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to the Food and Drug Administration to report adverse reactions, product defects, biologic product deviation, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance.

**Legal Proceedings:** We may disclose protected health information for the purpose of any judicial or administrative proceeding, in response to a court order (to the extent such disclosure is expressly authorized), in response to a subpoena, discover request or other lawful process.

**Law Enforcement:** We may disclose protected health information as long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes included (1) legal processes required by law, (2) Information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicions that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donations:** We disclose protected health information to a coroner or medical examiner for identification purposes, determining the cause of death, or for the coroner or medical examiner to perform other duties authorized by law. All permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information if we believe it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity:** We may use or disclose protected health information of individuals who are part of the Armed Forces for the activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to disclose your protected health information to authorized federal officials conducting national security and intelligence activities, including provision of protective services to the president or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and similar legally established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disorders:** Under the law, we must make disclosures to you when required by the Secretary of the Department of

Health R Human Services to investigate or determine our compliance with the requirements of section 164.500 et. seq

#### **4. Other uses and disclosures require your authorization.**

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

#### **Your Rights**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Request for copies must be in writing and there will be a charge of \$ .75 per page.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable use or anticipation of a civil, criminal or administrative proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by putting it in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will

be handled or specification of an alternative address or another method of contact. We will not request an explanation from you as the basis for the request. Please make this request in writing to our Privacy Officer.

You have the right to have your physician amend your protected health information. This means that you may request an amendment of protected health information about you in a designated record for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we, a rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosure we have made, of your protected health information. This right applies to the disclosures for purpose other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosure we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to exceptions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

**Complaints & Grievances** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer of your complaint. You have the right to file complaints or grievances without retaliation by those suspected in violation.

You have the **right** to have your physician amend your protected health information. This means that you may request an amendment of protected health information.

You may contact our Privacy Officer, Connie Papandrew at 516-616-0808 for further information about the complaint process. This notice was published and becomes effective on April 14, 2003.

**NASSAU CARDIAC DIAGNOSTICS  
SCOTT J. RATNER, M.D., F.A.C.C.  
407 FRANKLIN AVENUE  
FRANKLIN SQUARE, NEW YORK 11010  
(516) 616-0808**

**PRE-TEST INTRUCTIONS FOR STRESS TESTING**

You have been scheduled for a test designed to evaluate the circulation and function of your heart. This evaluation will provide your doctor with a large amount of information that will be helpful to you. Proper preparation is necessary to obtain the most precise results. Please contact us if you have additional questions or concerns about the test.

We will call and confirm your appointment approximately 24 hours prior to your test. If you cannot keep your appointment, please let us know so that you may give your allotted time to someone else.

Certain medications for the heart or blood pressure are best discontinued prior to testing. Check with your physician or ask a member of our staff for assistance concerning this. Only your physician can advise you about your medication.

**If you are having a treadmill test, please do not eat for 3 hours prior to testing.**

Wear comfortable clothing and shoes in which you can walk at a brisk pace. Rubber soled shoes or sneakers are preferred.

If you are having a nuclear stress test, which may go under the name of a Thallium or Cardiolite stress test, or a Persantine or Adenosine stress test, please be aware that your test will typically require two parts. Usually, the “stress” portion is done first. This test takes a little over an hour to complete. The second or “rest” portion of the examination may be done later that day or on a different day and usually requires less than 30 minutes. We will attempt to work around your schedule as much as possible and we will give you further instructions at the time of your test.

A word on your diet: Juices and water are permitted. Milk and dairy products should be avoided prior to nuclear stress tests. Coffee, tea, and caffeinated beverages must be avoided if you are having a nuclear stress test that utilizes medication rather than walking on the treadmill.

Dr. Ratner has performed more than 20,000 tests on people from age 9 to more than 90. He has been Board Certified in both cardiovascular disease, nuclear cardiology, critical care medicine and internal medicine. Please feel free to call if you have any questions or concerns.

**NASSAU CARDIAC DIAGNOSTICS  
SCOTT J. RATNER, M.D., F.A.C.C.  
407 FRANKLIN AVENUE  
FRANKLIN SQUARE, NEW YORK 11010  
(516) 616-0808**

Please complete the following prior to your test:

NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT \_\_\_ FT. \_\_\_\_\_ IN WEIGHT \_\_\_\_\_

NAME & ADDRESS OF ANY DOCTORS WHO ARE TO RECEIVE TEST RESULTS:

1. \_\_\_\_\_

2. \_\_\_\_\_

Please list any medications and the time of your last dose:

MEDICATIONS

TIME OF LAST DOSE

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Please check if you have had any of the following:

High blood pressue \_\_\_\_\_ Prior heart attack \_\_\_\_\_ Hear trouble in family \_\_\_\_\_

Diabetes \_\_\_\_\_ Prior Angioplasty \_\_\_\_\_ Chest Pain \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Angina \_\_\_\_\_ Breathing Problems \_\_\_\_\_

Smoking Now? \_\_\_\_\_ Smoked In Past? \_\_\_\_\_ Allergies \_\_\_\_\_

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**CONSENT FOR STRESS TESTING**

I hereby consent to engage voluntarily in a stress test on the advice of my physician, \_\_\_\_\_ to determine the state of my heart circulation. The information so obtained will help my physician in advising me as to the activities in which I may engage and as to the presence and/or severity of cardiac problems. Before the test, a brief interview and examination will be performed by a physician to determine if I have any conditions that would indicate I should not engage in this test. A physician will be present throughout testing, and he/she and his trained assistants will keep under surveillance my heart rate, blood pressure and electrocardiogram.

Stress tests may be performed on a treadmill, with the amount of effort increasing gradually until I fatigue or develop shortness of breath, chest discomfort or other conditions that would indicate the need to stop.

For nuclear stress tests, an intravenous catheter will be placed in a vein in my arm. These tests involve the administration of a small dose of a radioisotope such as thallium-201 or technetium-99m which allow my heart to be imaged with a special camera designed for this purpose. This is not a "dye". Reactions to this isotope are extremely rare. The amount of radiation exposure is comparable to a stomach X-ray and is considered minimal in comparison to the amount of information that can be obtained from this type of test.

For tests not performed on a treadmill, medications such as dipyridamole, adenosine or dobutamine may be administered. These medications may reproduce the effect of exercise on the heart. Occasionally, nausea, headache, facial flushing or the sense of malaise may occur. Other side effects, including asthma attacks, are rare.

For stress echocardiography, an ultrasound examination of my heart will be obtained prior to and post-stress.

Information concerning my test will be treated as privileged and confidential. It may be used for statistical or scientific purposes with my right of privacy retained.

I have read and understand the above. All questions have been answered to my satisfaction.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_