New York Gynecology Surgery

Pankaj Singhal, MD, MS, MHCM

325 West Main St, Babylon, NY 11702
Website: nygse.com **Phone:** 631-533-9733

New Patient Registration Form

Patient's Name: Email:

Date of Birth: Age: Sex: ☐ M ☐ F Social Security #:

Current Address: City: State: Zip Code:

Cell Phone #:

Employer Name & Address:

Preferred language:	Ethnicity: (Please check) ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Unknown Race: ☐ Asian ☐ Black or African American ☐ Native American ☐ White ☐ American Indian or Alaska Native

Emergency Contact Name: Phone #:

Who is your referring OB/GYN Doctor? How did you hear about us?	Who is your Primary Care Doctor?

Insurance Information

Primary Insurance: Patient is Subscriber/Policy Holder: ☐ YES ☐ NO	Secondary Insurance: Patient is Subscriber/Policy Holder: ☐ YES ☐ NO

Insured Information (If other than patient):

Subscriber / Policy Holder: Address: SSN: DOB:	Relationship to Patient: His or Her Employer:

Patient Signature: Date:

Pharmacy: Address: Phone #:

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Patient's Name: _____ Height (ft, in): _____ Weight (lbs): _____

Past Medical History *(please list any diagnosed medical conditions, such as asthma, diabetes, hypertension, etc..)*	
Past Surgical History *(please specify year if possible)*	
Medications *(Prescribed or Over the Counter)*	
Allergies	
Social History	Do you drink alcohol: YES ☐ NO ☐ If yes, how often _____. Are you a smoker: YES ☐ NO ☐ If yes, how often _____. Were you ever a smoker in the past: YES ☐ NO ☐
Obstetrical History	Total pregnancies: _____ Miscarriages: _____ Vaginal births: _____ Abortions: _____ C-sections: _____ Ectopic pregnancies: _____ Could you be pregnant: ☐ No ☐ Yes
Gynecological History	Date of last pap smear: _____ Result of last pap smear: _____ ☐ Normal ☐ Abnormal History of abnormal pap smears: YES ☐ NO ☐ If yes, when _____. Last menstrual period: _____ Age of first menstrual cycle: _____ Personal history of sexually transmitted disease? YES ☐ NO ☐
Family History	Do any of the following run in your family? Breast Cancer: YES ☐ NO ☐ Whom? _____ Ovarian Cancer: YES ☐ NO ☐ Whom? _____ Uterine Cancer: YES ☐ NO ☐ Whom? _____ Cervical Cancer: YES ☐ NO ☐ Whom? _____ Colon Cancer: YES ☐ NO ☐ Whom? _____

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Please check all boxes below that apply to you

Functional status: ☐ Independent ☐ Partially Dependent ☐ Totally Dependent
On steroids for a chronic condition: ☐ No ☐ Yes
On medication for diabetes: ☐ No ☐ Yes - oral medication ☐ Yes - insulin injection/pump
Hypertension requiring medication: ☐ No ☐ Yes
Do you have shortness of breath: ☐ No ☐ Yes - with moderate exertion ☐ Yes - at rest
Current smoker within the past 1 year: ☐ No ☐ Yes
History of severe COPD: ☐ No ☐ Yes
Dialysis: ☐ No ☐ Yes
History of acute renal failure: ☐ No ☐ Yes

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EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access and control my Protected Health Information. I also understand that in providing treatment, submitted billing and conducting healthcare operations. New York Gynecology Surgery (NYGS) may need to disclose my protected information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit New York Gynecology Surgery (NYGS) to disclose my protected health information for the purpose of appointment / test/ procedure reminders and follow up to the following individuals:

PLEASE LIST NAMES OF PEOPLE YOU AUTHORIZE MEDICAL INFORMATION BE RELEASED TO BELOW:

Name: _____ Relationship & Tel #: _____

Name: _____ Relationship & Tel #: _____

Name: _____ Relationship & Tel #: _____

Your health care is important to us.
To provide you with the best possible care, we occasionally send convenient text messages and emails to our patients about their healthcare and reminders for upcoming appointments.

Circle **YES** or **NO** to consent to Text Messages or Email appointment reminders.

I expressively permit New York Gynecology Surgery (NYGS) to disclose my health information for the purpose of appointment / test / procedure and follow up by leaving such information in the form of a message on the following record media:

Home answering machine: ☐ Telephone #: _____

Cell phone voicemail: ☐ Telephone #: _____

Signature of Patient: _____ Date: _____

Personal Representative: _____

Parent / Guardian: _____

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DISCLOSURE OF HEALTH INFORMATION:

Patient's Name: _____ Date of Birth: _____

I authorize the following using or disclosing party: New York Gynecology Surgery, PLLC to use or disclose the following health information.

- ☐ All my health information
- ☐ My Health information relating to the following treatment or condition:

_____

_____

- ☐ My health information covering from _____ (date) to _____ (date)
- ☐ Other: _____

This authorization ends: On (date) _____

A copy of this authorization is as valid as the orginal.

_____
Patient Name (Print)

_____ _____
Patient or Legally Authorized Representative Signature Date

_____ _____
Legally Authorized Representative (Print) Date

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OFFICE POLICIES

We would like to thank you for allowing us to provide for your healthcare needs. Please read all our office policies. Please keep a copy for future reference.

Appointments

- Any patient being treated is legally required to show photo identification (e.g. drivers license). Please also bring your insurance card with you to every appointment. You may be asked to reschedule your appointment if these documents are not available.
- If you arrive 30 minutes or more past your appointment time, you will be asked to reschedule your appointment. We will make every effort to reschedule your appointment for the same day as long as the schedule permits.
- We request that you call our office at least 24 hours in advance if you must cancel or reschedule your appointment. We reserve the right to charge a $40 fee for noncompliance.
- We try to confirm appointments as a courtesy but cannot guarantee this service for every appointment.
- We do not call to schedule routine physical appointments. We will send out a reminder card at the patients request. Please see front desk for more information.
- Please allow plenty of time for visits. These visits are very detailed; there are many issues to discuss and many tests to be completed or gone over.
- Lastly, regarding appointments, please know that we make every attempt to stay on time and see patients as close to their scheduled appointment times as possible. However, inevitably emergencies arise. Please be patient if we are running behind and know that you will always be given the best of care and detailed attention during your visit.

Contact Information

- You are responsible for providing any changes of contact information whenever such occurs. To facilitate communication, please provide us with your home phone number and an alternate number such as a cell phone.

Specialist Consultations / Referrals

- Sometimes it may be recommended for you to be seen by a specialist. This is sometimes important to ensure you receive the most comprehensive care. You will be given a list of specialists if a referral becomes necessary. Your compliance within a timely manner is extremely important. You must investigate which specialist accepts your insurance. If you encounter any problems or have questions, please call our office.
- Many insurance companies require referrals prior to being seen by a specialist. We will gladly complete this process for you. It is your responsibility to know whether your insurance requires a referral. If needed, please contact us at least 48 hours in advance. Please have available your appointment date and time, the name, address, and telephone number of the specialist you are seeing, the reason for the appointment, and any insurance ID numbers for that provider. Referrals typically have an expiration date and/or a set number of visits. If your referral expires, you must start from the beginning and complete the steps above.

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Medications

- For your safety, medications are not renewed over the phone, fax, or mail. Please ask for all refills at the time of your visit.
- We will not prescribe any medications without first examining you. While sometimes inconvenient, this is truly the safest way to practice medicine. If contacted after hours, you may be referred to a local hospital or clinic to ensure you are treated appropriately.

Results/ Outside Tests

- Tests such as throat and urine cultures are obtained in our office and sent to an outside laboratory for further testing.
- At times, it will be recommended for you to have a test (blood, radiology etc.) completed outside of our office. Your compliance within a timely manner is extremely important.
- If you wish to discuss test results with a particular provider, please let us know and that provider will contact you.
- We encourage you to schedule an office appointment whenever you wish to discuss your results in detail. This will ensure that you always receive your results and understand them completely.

Medical Records

- Fees for medical records will be charged as allowed by law. However, there is usually no charge if records are being forwarded directly to another physician. While we try to expedite this process, please allow 2 weeks for all requests for medical records to be completed.

Forms

- Due to the abundance of paperwork received on a daily basis, we require at least 48 hours to complete all forms. Please make sure your name and date of birth are written on the form. Call before coming to pick up your form to ensure that it is ready for pick up. We will mail forms when a self addressed stamped envelope is provided. We can also fax completed forms upon request.
- For multiple and/ or extensive forms, a fee may apply and more than 48 hours may be needed.

Medical Clearance

- Before surgical procedures, it is often required to have a medical clearance exam. Please schedule this appointment no more than 48 hours prior to your procedure. Please bring with you any paperwork given to you by the surgeon or hospital. Please have all required testing completed at least 24 hours before your appointment as results must be available to clear you. Your paperwork will be filled out prior to your procedure. You may be required to pick up the originals to bring with you the day of your surgery if they are not provided during your visit. We will fax a copy of all forms/ test results to the hospital as well.
- If you are sick or testing is incomplete, please understand that you will not be cleared for surgery.

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After hours

- Please dial 911 in the event of a true medical emergency.
- If you are sick after hours and you are worried and can not wait until the office reopens, please call our office number for further instructions. You will be given a number to call and your call will be forwarded to one of our staff members. If necessary, you may be referred to a local hospital or clinic to ensure you are treated appropriately

Dismissal from Practice

- NYGS reserves the right to dismiss patients from our practice for any reason, which may not be disclosed
- Prior to dismissal, NYGS will issue a certified letter informing you of your dismissal. All balances on your account will then be due in full.
- NYGS will provide EMERGENCY CARE ONLY for thirty (30) days after the date of the letter to allow you time to find another physician for your needs. You will not be eligible to see any of the physicians or providers at NYGS after the 30-day notice has expired.

Financial/ Insurance

- Please refer to our financial policy for all matters relating to financial matters and insurance.

We thank you again for choosing us to provide your healthcare needs and for reading through our office policy. Your signature below denotes acknowledgement of the policy and understanding of its content. Thank you for your cooperation.

Print Patient's Name

Date of Birth

Patient’s Signature

Date

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FINANCIAL POLICY

We are most appreciative of your decision to allow Veritas Medical Care to provide for your health care needs. We strive to provide the best possible medical care at all times. While uncomfortable, it is necessary to understand that our medical practice is a business like any other, and so financial policies such as this are necessary. Please appreciate and respect that we must enforce this policy so that we may pay our employees and continue to provide the highest standard of medical care. Please read this document carefully. We will be happy to discuss any aspects with you that are unclear. To ensure your best possible experience, we require that you agree to abide by this policy as indicated by your signature, before we treat you. Thank you.

1. Responsible Party
   - NYGS will gladly submit claims to your health insurance for the services provided. However, any charges accrued on the account are your responsibility. You will be expected to follow up on any unpaid or incorrectly paid charges, regardless of insurance coverage. We will be happy to assist you in any way we can, but you are ultimately responsible for timely payment of your account.
2. Billable Services
   - NYGS will charge for professional services, as well as supplies used for your care.
   - NYGS will charge for all follow-up services.
   - Occasionally, a patient will be scheduled for one type of service but the physician may diagnose and treat another problem in addition to the scheduled service. When appropriate, NYGS will charge for the additional service. Some insurance companies will not cover both services, which may result in a denial, a higher co-pay, or a return visit.
   - NYGS reserves the right to charge for extensive phone calls, reporting, consultation, coordination of care with other providers and/or other services provided on your behalf. Your insurance may not cover these services.
   - NYGS reserves the right to charge $40 for missed appointments, including same-day appointments. This fee may change without notice.
   - NYGS may charge a fee to complete multiple and/or extensive forms.
3. Due at Time of Service
   - If you have insurance coverage, all co-pays, co-insurance, and deductibles are due at the time of service without exception.
   - Some insurance companies require secondary co-pays for certain office procedures. Please make yourself aware of your policy to prevent confusion during your office visits.
   - We are required by contract with your insurance companies to charge all copays for all visits/procedures. Failure to do so is a breech on our part. We apologize but because of this, we cannot waive copays.
   - Payment in full is due at the time of service from non-NYGS patients (tourists, etc.), regardless of insurance coverage.
   - Payment in full is due at the time of service from accounts with a “bankruptcy” status.
4. Method of Payment
   - Payment to NYGS may be made in any of the following ways:
     i. Cash
     ii. Money Orders
     iii. Credit or debit card (Visa, MasterCard, Discover, and American Express)
5. Insurance Coverage
   - It is your responsibility to provide accurate insurance information to NYGS at the time of service. We will make every effort to verify coverage prior to each appointment but it is ultimately your responsibility to know all details about your insurance.
   - NYGS will create and submit claims to your health insurance on your behalf. However, we reserve the right to refuse insurance and collect payment in full from you in certain situations (i.e. out-of-state Medicaid, insurance information provided after claim filing deadlines, etc.).
   - NYGS will not submit claims directly to an auto insurance carrier. We will provide you with the claim form, and you will be responsible to submit the claim to the appropriate no-fault carrier.
   - It is your responsibility to verify that the doctor you have chosen is a participating provider under your insurance plan, prior to receiving services.
   - It is your responsibility to verify benefits under your plan. You will be responsible for any non-covered services and services considered to be over “usual, reasonable and customary (URC)”. You will also be responsible for amounts not paid by your insurance for any reason, unless the amounts are contracted under NYGS’s agreement with your insurance company.

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- NYGS must, under federal law, accurately report the services provided to you. Your insurance company may not pay for all services received. NYGS cannot change the service or diagnosis codes (unless there was an error) to establish, secure, or increase insurance reimbursement. We must report the exact services provided and the exact reason for providing them.
- In the event that your insurance carrier mails payment to you for a claim submitted by NYGS, it is your responsibility to ensure we receive payment.
- Your signature on this policy authorizes NYGS to release health information to insurance carriers when necessary for payment, and directs them to remit payment directly NYGS (assignment of benefits).

6. Statements
   - Account statements will only be sent on a monthly basis for accounts that have balances. Statements will show both patient (private) and insurance (suspense) balances. Private balances are due by the date shown.
   - It is your responsibility to provide NYGS with your correct address and phone number. If a statement is returned for an invalid address, your account may be turned over to an outside collection agency.
7. Interest
   - A finance fee of five dollars per month will accrue on accounts with private balances older than 30 days.
8. Payment Plan Options
   - NYGS may, and solely at their discretion, offer monthly payment plans to help you manage your health care costs.
   - The terms of each payment plan will be discussed, put in writing, and will require a signature to indicate agreement. The terms may vary, again, at the sole discretion of NYGS.
   - Payments are due on or before the agreed upon date. If payments are late or missed your account may be turned over to an outside collection agency without notice. Failure to follow any or all of the payment plan requirements will render the payment agreement null and void.
   - Payment plans are intended to help bring past-due amounts current. All future co-pays and deductibles are required at the time of service and will not be added to a payment plan.
9. Credits
   - Any insurance credits or over-adjustments will be returned to the appropriate insurance company.
   - Any patient credits or overpayments will first be used to pay past-due balances, including those that may have been referred to an outside collection agency.
   - If patient balances have been resolved, patient credits will be returned to you (or the person/organization that paid). Please allow 2-3 weeks for processing. Smaller credits (generally under $20.00) may be left on the account to be used for future co-pays and/or deductibles.
10. Collections
    - Your account may go to collections for the following reasons that include but are not limited to:
      i. Invalid patient demographic information that prevents us from contacting you regarding your account.
      ii. Failure to provide valid insurance information in a timely manner.
      iii. Failure to pay patient balances.
      iv. Failure to adhere to payment plan agreements.
    - NYGS makes every effort to work with you to keep your account out of collections. However, in the event that your account is referred to a collection agency, you will be responsible for the balance of the account in addition to a 30% collection fee. You will also be responsible for any interest, service fees and/or legal fees that accrue while your account is in collections.
    - Once your account is forwarded to a collection agency, NYGS will no longer provide services under any circumstances.
11. Returned Checks
    - Checks returned unpaid by your bank, regardless of the reason, will be posted back to your account in the original amount of the check, in addition to a $30.00 return check fee. You may be asked to pay in cash/charge for future visits.
12. Bankruptcy
    - If NYGS receives notice of a filed Bankruptcy case on your account, we will make the necessary adjustments according to bankruptcy law.
    - Your account will be placed in “bankruptcy” status, and you will be required to pay in full at the time of future service, regardless of insurance coverage. We will be happy to submit a claim to your insurance on your behalf and, if your insurance pays on the claim, you will receive a refund.
    - Your account will remain in a “bankruptcy” status for two (2) years from the bankruptcy file date. If there has been no collection activity (multiple statements, letters, etc.) during that time, the bankruptcy status will be removed from your account and normal payment policies will apply.

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13. Dismissal from Practice
    - NYGS reserves the right to dismiss patients from our practice for non-payment. If you have established a history of non-payment on your account, you may be eligible for dismissal.
    - Prior to dismissal, NYGS will issue a certified letter informing you of our intent to dismiss unless payment in full is made on your account. Payment in full includes your current account balance, in addition to any amounts that have been referred to an outside collection agency.
    - If payment is not made within the specified amount of time, a certified dismissal letter will be issued. NYGS will provide EMERGENCY CARE ONLY for thirty (30) days after the date of the letter to allow you time to find another physician for your child. You will not be eligible to see any of the physicians or providers at NYGS after the 30-day notice has expired.
14. Questions or Concerns
    - If you have any questions regarding your account, or need clarification on any of the items above, please contact us immediately and certainly before signing this form. Our billing staff will be happy to assist you with any future concerns as they arise. They may be contacted in person or on the phone from 9:00 a.m. to 5:00 p.m. Monday-Friday.

We thank you again for choosing us to provide for your healthcare needs and for reading through our financial policy. Your signature below denotes understanding of the policy and agreement to abide by its provisions.

Print Patient's Name:

Date of Birth:

Patient’s Signature

Date

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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 IT CAREFULLY.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices please contact:

Michele Lupo
NYGS
325 West Main St
Bldg 1
Babylon, NY 11702

Effective Date of This Notice: September 20th, 2026

I. How the practice may Use or Disclose Your Health Information

This practice collects health information from you and stores it in a computerized chart. This is your medical record. The medical record is the property of the NYGS, but the information in the medical record belongs to you. The practice protects the privacy of your health information.

The law permits the practice to use or disclose your health information for the following purposes:

1. Treatment.

2. Payment.

3. Regular Health Care Operations.

4. Information provided to you.

5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by law. As required by law, we may use and disclose your health information.

7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

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9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

10. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

11. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

12. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

13. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or the privacy board.

14. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military, national security, prisoner and government benefits (only for health plans) purposes.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

17. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

18. Change of Ownership. In the event that the practice is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When the practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, the practice will not use or disclose your health information without your written authorization. If you do authorize the practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses
2. and disclosures of your health

information. The practice is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location within 30 days of the written request.

3. You have the right to inspect and copy your health information.

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4. You have a right to request that the practice amend your health information that is incorrect or incomplete. The practice is not required to change your health information and will provide you with information about the practice's denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your health information made by the practice, except that the practice does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you) and 16 (certain government functions) of section I of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices.
If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact

Michele Lupo

IV. Changes to this Notice of Privacy Practices
The practice reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, the practice is required by law to comply with this Notice.

V. Complaints
Complaints about this Notice of Privacy Practices or how the practice handles your health information should be directed to:

Michele Lupo

Signature of Patient/Patient's Representative

Date

Relationship to the Patient

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PATIENT PHOTO, VIDEO, AND MEDIA RELEASE FORM

Patient Name: **Date of Birth:**

Provider/Practice Name: New York Gynecology Surgery (NYGS)/ Pankaj Singhal

1. Purpose of Media
I hereby grant **NYGS** and its authorized representatives permission to take photographs, video recordings, and/or audio recordings of me. These materials may capture my likeness, facial features, or specific areas of treatment.

2. Scope of Authorized Use
I authorize the practice to use, publish, and distribute these materials across the following platforms:

- The practice's official website and blog.
- Social media profiles (e.g., Instagram, Facebook).
- Printed office brochures, educational pamphlets, and waiting room displays.

3. Privacy and Confidentiality
The practice agrees to protect my privacy by withholding my full name, contact information, and specific medical condition details from any public posts unless explicitly permitted. However, I acknowledge that due to the nature of photography, complete anonymity cannot be guaranteed if my face or distinct markings are visible.

4. Terms and Compensation

- **No Compensation:** I agree that I will receive no financial payment, royalties, or compensation for the creation or use of these materials.
- **Ownership:** I agree that all digital files, negatives, and prints are the exclusive property of the practice.
- **Voluntary Care:** I understand that my refusal to sign this media release will **not** alter, compromise, or affect the quality of healthcare treatment I receive here.

5. Right to Revoke
This authorization remains effective unless revoked. I reserve the right to revoke this consent at any time by providing a written notice to the office. I understand that a revocation will apply moving forward but cannot retract materials already printed or distributed online.

Patient / Legal Representative Signature

Printed Name & Relationship (if signing for a minor)

Date: