



Digestive Health Center of Huntington, Inc.

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____

Email

Please check one as your preferred email for communications

Personal: _____ Work: _____

Sex

Male Female Other

Allergies

Patient has no known allergies Patient has no known drug allergies
 Eggs Latex Sulfites Soybeans Sulfa (Sulfonamides)
 Penicillins Other: _____

Reaction:

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Current Medications

None

Name	Dose	LAST DOSE

Diagnostic Studies/Tests

None
 Previous Colonoscopy Previous EGD
When: _____ When: _____

Past or Present Medical Conditions None**Gastroenterology**

- | | | | |
|-------------------------------------------|------------------------------------------|------------------------------------------------|--------------------------------------------------------------|
| <input type="radio"/> Diverticulitis | <input type="radio"/> Diverticulosis | <input type="radio"/> Colon polyp history | <input type="radio"/> Colon cancer |
| <input type="radio"/> Crohn's Disease | <input type="radio"/> Ulcerative Colitis | <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Gastroesophageal Reflux Disease (GERD) |
| <input type="radio"/> Barrett's Esophagus | <input type="radio"/> Celiac Disease | <input type="radio"/> Bowel Obstruction | <input type="radio"/> Fatty Liver |
| <input type="radio"/> Cirrhosis | <input type="radio"/> Hepatitis B | <input type="radio"/> Hepatitis C | <input type="radio"/> Pancreatitis |
| <input type="radio"/> Gastric Ulcer | <u>Other:</u> | | |

Cardiology

- | | | | |
|------------------------------------------------|-----------------------------------------------|-------------------------------------------------|----------------------------------------------|
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Heart Attack | <input type="radio"/> Heart Murmurs |
| <input type="radio"/> Mitral Valve Prolapse/MR | <input type="radio"/> High blood pressure | <input type="radio"/> High Cholesterol | <input type="radio"/> Atrial Fibrillation |
| <input type="radio"/> Pacemaker/Defibrillator | <input type="radio"/> Stroke | <input type="radio"/> Transient Ischemic Attack | <input type="radio"/> Coronary Artery Stents |
| <u>Other:</u> | | | |

Pulmonology

- | | | | |
|------------------------------|-----------------------------------|--------------------------------|---------------|
| <input type="radio"/> Asthma | <input type="radio"/> Sleep apnea | <input type="radio"/> C.O.P.D. | <u>Other:</u> |
|------------------------------|-----------------------------------|--------------------------------|---------------|

Other

- | | | | |
|---------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------|-----------------------------------------|
| <input type="radio"/> Arthritis | <input type="radio"/> Breast cancer | <input type="radio"/> Cataracts | <input type="radio"/> Bleeding disorder |
| <input type="radio"/> Diabetes Mellitus, Insulin Dependent (Type 1) | <input type="radio"/> Diabetes Mellitus, Non-Insulin Dependent (Type 2) | <input type="radio"/> Glaucoma | <input type="radio"/> Hyperthyroidism |
| <input type="radio"/> Hypothyroidism | <input type="radio"/> HIV infection | <input type="radio"/> Kidney disease | <input type="radio"/> Kidney stones |
| <input type="radio"/> Lung cancer | <input type="radio"/> Ovarian Cancer | <input type="radio"/> Prostate Cancer | <input type="radio"/> Seizures |
| <input type="radio"/> Skin Cancer | <u>Other:</u> | | |

Previous Procedures None

- | | | | | |
|-------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|
| <input type="radio"/> Cholecystectomy (Gallbladder removal) | <input type="radio"/> Appendectomy | <input type="radio"/> Tonsillectomy | <input type="radio"/> Colectomy (Colon Resection) | <input type="radio"/> Small Bowel Resection |
| <input type="radio"/> Bariatric Surgery | <input type="radio"/> Hemorrhoid banding | <input type="radio"/> Hemorrhoidectomy | <input type="radio"/> Coronary Artery Bypass Graft (CABG) | <input type="radio"/> Hernia Repair - Inguinal/Umbilical |
| <input type="radio"/> Hysterectomy-Partial/Total | <input type="radio"/> Abdominal aortic aneurysm (AAA) repair | <input type="radio"/> Heart valve replacement | <input type="radio"/> Spinal Surgery | <input type="radio"/> Joint Replacement |
| <input type="radio"/> Mastectomy L Breast | <input type="radio"/> Mastectomy R Breast | <input type="radio"/> Vasectomy | <input type="radio"/> Bilateral Tubal Ligation (BTL) | <input type="radio"/> C Section |
| <input type="radio"/> Infusion Port Placement | <input type="radio"/> Cardiac Cath - with stent placement | <u>Other:</u> | | |

Social History**Marital Status**

- | | | | | |
|------------------------------|-------------------------------|--------------------------------|---------------------------------|-------------------------------|
| <input type="radio"/> Single | <input type="radio"/> Married | <input type="radio"/> Divorced | <input type="radio"/> Separated | <input type="radio"/> Widowed |
|------------------------------|-------------------------------|--------------------------------|---------------------------------|-------------------------------|

Alcohol

- | | |
|------------------------------------|-----------------------------|
| <input type="radio"/> None | <input type="radio"/> Daily |
| <input type="radio"/> Occasionally | |

Caffeine

- | |
|----------------------------|
| <input type="radio"/> None |
|----------------------------|

1 cup daily

2 or more cups daily

Tobacco

Smoking Status

Current every day smoker

Current some day smoker

Former smoker

Never smoker

Smoker, current status unknown

Light tobacco smoker

Heavy tobacco smoker

Unknown if ever smoked

Type Cigarettes

Quantity

Frequency

Drug Use

None

Type Recreational

Quantity

Number

Frequency

Exercise

None

Yes

Review Of Systems

Cardiovascular

None

- chest pain
- dyspnea with exercise
- irregular heart beat
- orthopnea
- palpitations
- peripheral edema
- syncope

Y	N
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Neurological

None

- dizziness
- fainting
- frequent headaches
- migraine
- numbness or tingling
- seizures
- tremors
- vertigo
- memory loss

Y	N
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Respiratory

None

- asthma
- cough
- dyspnea
- excessive sputum
- coughing up blood
- shortness of breath with exercise
- wheezing

Y	N
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Gastrointestinal

None

- abdominal pain
- abdominal swelling
- change in bowel habits
- constipation
- diarrhea
- gas
- heartburn
- jaundice
- nausea
- rectal bleeding
- stomach cramps
- vomiting
- difficulty swallowing

Y	N
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Reviewed with

Patient

Parent

Guardian

Not Present

Signature

Signature

Date

Digestive Health Center of Huntington, Inc
 195 East Main Street
 Huntington, NY 11743
 Tel: 631-385-8677 Fax: 631-385-0611

PATIENT INFORMATION

Name: _____ SS#: _____ Birth Date: ____/____/____ Age: _____
Last First MI

Sex: _____ Marital Status: Single Married Widowed Divorced

Ethnicity: Hispanic Non-Hispanic

Race: White Asian: _____ (Specify, if known - e.g., Chinese)
 Black/African American Native Hawaiian or Pacific Islander
 American Indian or Alaskan Native Other: _____ (Please describe)

Phone (____) _____ Work Phone (____) _____
Area Code Area Code

Address: _____
Street City State Zip

Emergency Contact Person: _____
Name Phone Relationship

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary. Any remaining balance after receipt of explanation of benefits from your primary and secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER: _____

I request that payment of authorized Medicare/ other insurance company benefits be made either to me on my behalf or to the Digestive Health Center of Huntington for any services furnished me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information).

Signature of Patient or Responsible Party Date

LABORATORY TESTING

During the course of your procedure it may be necessary for your physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New York now requires clinical laboratories to directly bill patients for their testing services, or that person's legal representative. Therefore, it is necessary for the Digestive Health Center of Huntington to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, then billing for the services will go directly to you as the patient. Please complete and sign below so that we may direct this issue in the proper manner. Thank you for your cooperation with this matter.

- Yes, I am giving the laboratory permission to bill my insurance company.
- No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for payment of services directly to the laboratory

Signature of Patient or Responsible Party Date

REGISTRATION



Digestive Health Center of Huntington, Inc.

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

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Denise Ferrandina, Administrator, is in charge of privacy matters at our Surgery Center. You can contact her at (631) 385-8677 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. Such as, "if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure information concerning HIV/AIDS)".

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you, such as, "under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered."

Federal laws provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you, such as, our accountants may see your name, dates of treatment and procedure codes during audits of our books. As a possible second example: we may use your information for financial services, quality assurance, risk deduction and claim management purposes without our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required for law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States;

195 East Main Street · Huntington, NY 11743 · Phone (631) 385-8677 · Fax (631) 385-0611



Digestive Health Center of Huntington, Inc.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave you a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.

You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for disclosures we make to you, or to carry out treatment, payment or health care operation, or as requested by your written authorization, or as permitted or required under 45 CFR & 164.50, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our facility, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Digestive Health Center of Huntington, 195 East Main Street, Huntington, NY 11743.

No retaliatory action will be taken against you for any complaint you make.

195 East Main Street • Huntington, NY 11743 • Phone (631) 385-8677 • Fax (631) 385-0611

RECEIPT OF HIPAA PRIVACY NOTICE

I make the following special request for confidential communications:

Please initial here _____ I authorize the physicians and/or staff to leave messages on my answering machine or voice mail.

Or

Please initial here _____ I request **NOT** to receive messages.

I have received a paper copy of this notice

Signature

Print Name

Date



Digestive Health Center of Huntington, Inc.

May 18, 2009

RECEIPT OF INFORMATION

I have read, reviewed and understand information I received prior to the date of my procedure at the Digestive Health Center of Huntington.

PATIENT BILL OF RIGHTS

ADVANCED DIRECTIVE POLICY

FINANCIAL INTEREST DISCLOSURE

Signature

Print Name

Date

Memo

To: All patients at Digestive Health Center of Huntington
From: Denise Ferrandina
Date: 6/16/2010
Re: Patient ride

We strongly advise that the person accompanying you remain in our waiting room. We do understand that it may not be possible. We would ask your ride to take our card and call us regarding the status of your discharge.

Thank you,



Denise Ferrandina
Administrator



Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

As a patient in a Clinic in New York State, you have the right, consistent with law, to:

1. Receive services(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
2. Be treated with consideration, respect and dignity including privacy in treatment;
3. Be informed of the services available at the center;
4. Be informed of the provisions for off-hour emergency coverage;
5. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
6. Receive an itemized copy of his/her account statement, upon request;
7. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
8. Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;
10. Refuse to participate in experimental research;
11. Voice grievances and recommend changes in policies and services to the center's staff, the operator and New York Department of Health without fear of reprisal;
12. Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to New York State Department of Health's Office of Primary Health Systems Management; Privacy and confidentiality of all information and records pertaining to the patient's treatment;
13. Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;
14. Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access
15. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and
16. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.
- 17.

to the

Digestive Health

Center of

Huntington

an Ambulatory

Endoscopy Center

195 East Main Street Huntington, New York 11743
Tel: 631-385-8677 Fax: 631-385-0611

Website: www.dhchuntington.com

**Notice to all Patients of Digestive Health
Center of Huntington:**

Because of concerns that there may be conflict of interest when a physician refers a patient to a healthcare facility in which the physician has a financial interest, The Center for Medicare and Medicaid along with New York State has passed certain criteria for disclosure to the patients scheduled for procedures at the Digestive Health Center. The condition set forth is that I disclose this financial interest. This disclosure is intended to help you make a fully informed decision regarding your healthcare. If you require any other information regarding alternative providers, please consult the staff of Digestive Health Center.

Sincerely,

Paul Bermanski, MD

Richard Fried, MD

David Purow, MD

Michaels Moseson, MD

Mark Dobriner, MD

Zvi Alpern, MD

Northwell Health

ADVANCE DIRECTIVE POLICY

**FOR AN AMBULATORY SURGERY CENTER,
DEDUCTIBLES, AND CO-INSURANCE).**

- Digestive Health Center of Huntington is an outpatient surgery center that is limited to elective surgery only and performs no high-risk surgical procedures.
- It is the policy of Digestive Health Center of Huntington to recognize the Health Care Agent of the patient should circumstances require, but in the event of an emergency the patient will be stabilized and transferred to a hospital as soon as possible.
- Therefore the Digestive Health Center of Huntington will not acknowledge DNR (Do Not Resuscitate) orders on any patient while in this Ambulatory Surgical Center.
- For information on advance directives, reference: <http://www.noah-health.org/en/rights/endoflife/adforms.html> (By state)

If you have any concerns, please do not hesitate to contact the billing department 631-385-8677

BILLING INFORMATION

Please Be advised that the Digestive Health Center of Huntington, Inc. (DHC), an article 28 Ambulatory Endoscopy Center. **WILL VERIFY YOUR INSURANCE BENEFITS PRIOR TO YOUR PROCEDURE, BUT THERE MAY BE INFORMATION NOT AVAILABLE TO US AS THE PROVIDER. INFORMATION GIVEN IS NOT A GUARANTEE OF PAYMENT. IT WOULD BE IN YOUR BEST INTEREST TO CALL YOUR CARRIER AND GET THE DETERMINATION OF THE BENEFITS COVERED IN THE SURGERY CENTER SO THAT YOU HAVE ALL INFORMATION AVAILABLE TO DETERMINE YOUR FINANCIAL RESPONSIBILITY (INCLUDING COPAYMENTS**



Digestive Health Center of Huntington, Inc.

WELCOME LETTER

OCTOBER 1, 2010

TO ALL PATIENTS SCHEDULED AT THE DIGESTIVE HEALTH CENTER:

FOR YOUR INFORMATION, PLEASE BE AWARE THAT DIGESTIVE HEALTH CENTER IS AN ARTICLE 28 ENDOSCOPY AMBULATORY SURGERY CENTER.

WE WILL VERIFY YOUR INSURANCE BENEFITS PRIOR TO YOUR PROCEDURE, BUT THERE MAY BE INFORMATION NOT AVAILABLE TO US AS THE PROVIDER. INFORMATION GIVEN TO US IS NOT A GUARANTEE OF PAYMENT.

IT WOULD BE IN YOUR BEST INTEREST TO CALL YOUR CARRIER AND GET THE DETERMINATION OF THE BENEFITS COVERED IN THE SURGERY CENTER SO THAT YOU HAVE ALL INFORMATION AVAILABLE TO DETERMINE YOUR FINANCIAL RESPONSIBILITY (INCLUDING COPAYMENTS FOR AN AMBULATORY SURGERY CENTER, DEDUCTIBLES, AND CO-INSURANCE).

THANK YOU FOR YOUR COOPERATION IN THIS MANNER. IF THERE IS ANY OTHER INFORMATION YOU REQUIRE FROM THE SURGERY CENTER, PLEASE DO NOT HESITATE TO CONTACT ME.

THANK YOU FOR YOU PATIENCE,

DENISE FERRANDINA
ADMINISTRATOR

Digestive Health Center Cancellation and Referrals Policy

If patient is a minor, please print the name of parent of guardian in place of patient's name below:

CANCELLATIONS:

I _____ as of this date _____ I understand that if I am scheduled for a procedure at Digestive Health Center of Huntington and do not cancel at least 48 hours in advance and do not show up, I will be charged a fee of \$ 100 , which I WILL pay when billed.

REFERRALS:

I _____ as of this date _____ understand that it is my responsibility to know if my insurance requires referrals. It is also my responsibility to obtain a referral BEFORE the date of my appointment. I understand that if I show up for an appointment without a valid referral, I will NOT be seen and will need to reschedule. Further, I understand that it is not the office's responsibility to obtain my referral at any time, for any reason. I understand that disputing this with the receptionist or office manager will not change this policy and I will still have to reschedule my appointment if I show up without a valid referral.

By signing here I am stating I understand and agree to the above policies. I also understand if I do not sign this agreement, I will not be seen in this office.

Print: _____

Sign: _____

Date: _____

Dear Patient:

North Shore-LIJ Anesthesiology, P.C. is the provider of anesthesia services at Digestive Health Center of Huntington.

The anesthesiologist for your procedure will be Lyudmila Altshuler, MD or Pavel Berklayd, MD.

To ensure seamless coverage for your procedure, we participate with a broad range of health insurance plans ("Health Plan"). You may find this list on our website: www.northwell.edu/AnesthesiaPC.

After your procedure, we will bill your Health Plan. You will be responsible for any copayment, coinsurance, or deductible your Health Plan deems as the patient's responsibility.

You may request an estimate of the cost associated with your anesthesia services. Please call us at 914-666-8866 if you would like an estimate.

Thank you.

North Shore-LIJ Anesthesiology, P.C.

I agree to pay for any copayment, coinsurance, deductible, or other patient responsibility amount.

All claim checks received by the patient from the Health Plan must be sent to North Shore-LIJ Anesthesiology, P.C. within 10 days of receipt to avoid collections.

Signature _____

Print Name _____

Date _____

North Shore-LIJ Anesthesiology, P.C. Participating Insurance Plans

- Aetna
- Affinity Health Plan
 - Child Health Plus
 - Exchange Plans
 - Essential Plans 1-4
 - Medicare
 - Medicaid
- AgeWell New York
- CareConnect
- CenterLight Healthcare
- Cigna
- ElderPlan
- EmblemHealth
 - GHI EPO/PPO; Network Access
 - HIP Commercial – NY Metro; Prime; Premium; ConnectiCare
 - HIP Commercial – Select Care Essential (BHP) 1 and 2
 - Medicare Essential; VIP Prime; GHI Medicare Choice PPO; Associate Dual: ConnectiCare
 - Medicaid; Enhanced Care (MMC); Enhanced Care Plus (HARP); Essential (BHP) 3 and 4
- Empire Blue Cross Blue Shield
 - Commercial
 - Individual Exchange
 - Small Group Exchange
 - Medicare
- Empire BlueCross BlueShield HealthPlus
 - Medicaid
 - Child Health Plus
 - HARP
 - Essential Plan (BHP) 1 -4
- NYSHIP Empire Plan / UnitedHealthcare Empire Plan
- Fidelis Care
 - Exchange
 - Medicare
 - Medicaid
 - Child Health Plus
 - HARP
 - Essential Plans 1-4
 - FIDA
- HumanaLiberty Health Advantage
- MagnaCare
- Oxford Health Plans
 - Commercial
 - Medicare
- POMCO
- UnitedHealthcare
 - Commercial
 - Exchange
 - Medicare
 - Medicaid
 - Essential Plans 1-4
- WellCare
 - Medicare
 - Medicaid