



MSSNY HIT SERVICE BUREAU: PRACTICE QUESTIONNAIRE

Please print and complete the following: Check: MSSNY Member Non-member

1. Lead Physician Name: _____

2. Street Address: _____

City/ST: _____ **Zipcode:** _____ **County:** _____

3. Practice Size: 1 – 5 6 – 10 11 – 15 16 – 25 Over 25

Check Types of Eligible Professionals in Practice: MD DO PA NP Midwife

4. Are you interested in the Federal Incentive Program? (Choose One) Medicare Medicaid

5. Are you aware of the eligibility requirements for the Medicare incentive? Yes No

Medicaid incentive? Yes No

6. Do you currently use an Electronic Health Record system? Yes No

If yes, has it been certified for meaningful use? Yes No Don't know

Indicate: Vendor: _____ Product/Version: _____ Purchase Date: __/__/__

7. Are you currently involved in your local RHIO (Regional Health Information Organization) or HIE (Health Information Exchange)? Yes No

If yes, please specify: _____

8. How did you hear about the MSSNY HIT Service Bureau? _____

9. Would you like a representative from the MSSNY HIT Service Bureau contact you? Yes No

10. Please specify the best method of contact: eMail: _____

Telephone: _____ Best Time to call: Yes No

MAIL and FAX INFORMATION

Please mail to: The Medical Society of the State of New York
c/o MSSNY HIT Service Bureau
One Commerce Plaza
Suite 408
Albany, NY 12210

OR Fax to: MSSNY HIT Service Bureau
1-518-465-0976

OR

SCAN and eMail to: Ron Pucherelli at: rpucherelli@mssny.org or Eileen Clinton at: eclinton@mssny.org