

MRN _____

General Information

Name _____ Date of Birth _____ Sex: M / F
Email _____
Social sec # _____ Marital status: Single / Married / Divorced / Widowed
Local address _____ Community Name _____
City _____ State _____ Zip _____
Home phone _____ Work phone _____ Cell phone _____
Secondary address _____ Community Name _____
City _____ State _____ Zip _____
Pharmacy name _____ Phone _____ Fax _____
Employment status: employed / not employed / retired / student
Employer: _____ Occupation _____

Primary Insurance

Insurance name _____
Policyholder's name _____ Policyholder's Date of Birth _____ Relationship to insured _____

Secondary Insurance

Insurance name _____
Policyholder's name _____ Policyholder's Date of Birth _____ Relationship to insured _____

Doctor Information

Primary Care Physician _____ Phone _____
Referring Physician _____ Phone _____

Race: choose one

- American Indian/Alaskan Native
- Asian
- Black or African American
- Caucasian White
- Multiracial
- Native Hawaiian or other Pacific Islander
- Refused/Declined

Language: choose one

- Declined to Specify
- English
- Sign Language
- Spanish

Ethnicity: choose one

- Declined to Specify
- Hispanic or Latino
- Not Hispanic or Latino
- Refused / Declined
- Unknown / Not Reported

Accident Information

Is visit related to an auto accident or work-related accident? Y / N

****Disclaimer: The Hirsh Center is unable to treat any new patient whose visit is related to an auto or work-related accident****

Emergency Contact

I authorize the physicians and/or staff of The Hirsh Center to communicate with the following individual about my health care which may include information about my medical diagnoses, insurance eligibility and changes, appointments, and/or medication changes.

Emergency Contact _____ **Relationship** _____ **Phone** _____

Financial Responsibilities

- I understand that I am financially responsible for services rendered to me by the physicians and/or staff of The Hirsh Center. This includes providing current insurance information needed to submit claims to my insurance plan(s) on my behalf. The Hirsh Center will submit claims only to primary and secondary insurance policies.
- I understand that I am responsible for paying my co-pay, co-insurance or deductible at the time services are rendered.
- I understand that if I have a high deductible plan, it is required that I either keep a credit card on file or put down a \$250 (cash or credit card) deposit prior to seeing the doctor and pay the additional balance for services rendered at time of check out.
- I am aware if I have Medicare with no secondary insurance, I am responsible for keeping a credit card on file or paying the remaining 20% when services are rendered.
- I understand that failure to provide current insurance information will result in my becoming responsible for payment of services rendered to me.
- For services that require orchestrating receipt of specialty pharmacy medications, submitting prior authorization requests and enrolling and renewing in patient assistance programs, a \$50 Care Coordination Fee will be charged prior to the commencement of applicable services.
- I authorize the physicians and/or the staff of The Hirsh Center to act as my designated representative as part of the appeal process should this be required by my insurance plan(s)
- I authorize my insurance plan(s) to communicate with the physicians and/or staff of The Hirsh Center in all aspects of the submission and appeal process.
- I understand that The Hirsh Center will put forth its greatest effort in collecting payment from my insurance plan(s). If they have exhausted all efforts, I will be responsible to pay for the services received.

Collections and Associated Fees

I understand services rendered to me by the physicians and/or staff of The Hirsh Center are my responsibility. Refunds which may be due will be returned via check mailed to your address on file. I understand that any account balance that is not paid within 60 days may begin our collection process. Balances remaining unpaid by 90 days may be reviewed and sent to a collection agency. If my account is sent to a collection agency, I will be responsible for all costs relating to the collection of my debt. This could include, but not be limited to, an additional 20% to 40% in fees assessed by the agency to which my account is sent.

Special Accommodations

If you require a special accommodation for your appointment, you or your representative must notify The Hirsh Center at least one week (7 days) in advance of your appointment. If you are a new patient, notice must be provided at the time your appointment is scheduled. Under the American with Disabilities Act, "Providers are responsible for incurring all costs incurred for providing reasonable aid and cannot pass the charge onto the patient or their insurance company." **However, if you have requested an accommodation and you either do not show or do not cancel 24 hours prior to your appointment, you could be responsible for the cost incurred by the third party responsible for providing these services to you.**

By signing below, I acknowledge that I have read and understand all the above:

Patient signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTIFICATION OF THE HIRSH CENTER NOTICE OF PRIVACY PRACTICES

We are required to make available to you a copy of our Notice of Privacy Practices and provide you with a copy if requested. Please sign this form to acknowledge that you have been advised and made aware of our Notice of Privacy Practices.

Patient Name (Please Print): _____

Patient Signature: _____ **Date:** _____

You may refuse to sign this acknowledgement.

Reason for refusal: _____

The Hirsh Center Staff Signature: