Long Island Medical P.C

Personal Information

*Name : _____

*Address: _____

_____

*Social Security : ____ ____ ____

Age: ____ *Date of Birth: ____/____/____

*Sex: Female Male

Marital Status: Single Married Separated Divorced Widowed

*Ethnic : Hispanic/Latin Non Hispanic/ Latin Refuse to Report

*Race: White Hispanic/Latin Afr.American/Black Asian Other Refuse to Report

*Language Spoken: Hindi Tamil Spanish English Other

*Home Phone: _____

Mobile Phone: _____

*Email: _____

Employer: _____

Employer Phone: _____

*Emergency Contact: _____

* Relation: _____ Emergency Phone: _____

* Referring Physician: _____

*Primary Physician: _____

* Physician Phone: _____

Receptionist will require a copy of your Insurance card and picture ID

We accept various methods of payment including Cash/Check/ Credit Card

Primary Insurance Information

Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

*Subscriber's Name: _____

*Subscriber' SSN: ___/___/____

*Relationship: Self Parent Guardian Spouse Other: _____

*Subscriber's DOB: _____

Subscriber's Effective Date: ____/____/____

*Policy Number: _____

*Group Number: _____

Subscriber's Employer: _____

Employer's Address:

_____

_____

Employer's Phone #: _____

Secondary Insurance Information

Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

*Subscriber's Name: _____

*Subscriber' SSN: ___/___/____

*Relationship: Self Parent Guardian Spouse Other: _____

*Subscriber's DOB: _____

Subscriber's Effective Date: ____/____/____

*Policy Number: _____

*Group Number: _____

Subscriber's Employer: _____

Employer's Address:

_____

_____

Employer's Phone #: _____

Financial Agreement / receipt of HIPPA Privacy Notice / Consent for treatment

We find that open communication with our patients regarding our financial policy assists us in providing the best possible service to you. Please take the time to read these policies concerning medical insurance benefits. If you have questions, please feel free to ask. If you are having an office based endoscopic procedure, the policies below also apply to anesthesiologist contracted by long island medical p.c.

Medical insurance is intended to be only be an aid and rarely covers 100 % of the total cost of your medical care. Every plan has its own provisions, which we must abide by. Certain cost will be passed along to the patient, such as deductibles co payments and co insurance amounts. As a patient you have certain responsibilities (1) to pay amounts not covered by your insurance carrier (2) to be acknowledged about your plan's covered and non-covered services (3) to notify the register if there are any changes in your coverage. We will do our best to work within your plan to help you receive maximum benefits. Please be advised that responsibility for full payments is solely yours, whether or not you have insurance. If it becomes necessary to send your account to a collection agency or attorney you will be responsible for all costs, interest and attorney fees. There is a $25 fee for all the checks returned for insufficient funds. LIMPC reserved the right for all the future payments by the undersigned to be paid in cash or money order. For all the patient balances over 30 days there is a $ 5.00 statement processing fee, cumulative per month, on unpaid monies due to the practice limpc reserves the right to charge a $25.00 no show/ cancellation fee for any office related visits and A $ 100 for procedures.

Managed care plans: We participate with a full range of insurance plans in order to offer flexibility to our patients. Our medical providers strictly follow the regulations and guidelines of these plans. On the date of service, we are contractually obligated to collect any appropriate co payments, co insurance and deductibles from you, the patient as our agreement with carriers.

Medicare: We participate with Medicare and closely follow their billing guidelines. You will be responsible for your $100 deductible, or any unmet portion thereof at the time service. We will also collect the 20 % co insurance portion of Medicare's approved charges for covered medical services upon being informed of them by Medicare. If you have supplemental coverage, we will automatically submit your co insurance to that insurance company. Since your Medicare supplemental insurance will not cover certain specified medical services, it is your responsibility to pay the fees for the non covered services when we inform you about them, and ask you to sign an advance beneficiary notice as required by Medicare.

All other insurance: due to the complexities of insurance billing, it is necessary for us to collect the appropriate percentage payment or deductible due at the time of service as directed by your insurance company. We will then submit the claim to the insurance carrier, who will then reimburse long island medical p.c for their portion of the covered services. If the carrier sends a reimbursement check to you, it is your responsibility to sign over to long island medical p.c immediately. Failure to do so will lead to sending your account to a collection agency or attorney.

Secondary insurance: Patients who are covered by more than one medical insurance carrier should notify the receptionist at the time of registration. It is your responsibility to the limitations of your supplemental/secondary policy. If you have two insurance policies, the co payment of the primary insurance is collected on the time of service.

CONSENT FO THE RELEASE OF MEDICAL INFORMATION:

As the provider of healthcare services, we are hereby authorized to release any medical information required in treating you, for payment for service rendered to you or for other healthcare operations of LIMPC, or the healthcare operations of an LIMPC contracted anesthesiologist if applicable. Before we release information to parties other than for treatment, payment of your account or healthcare operations, we will review a specific authorization from you. By signing below, you acknowledge that you received LIMPC's HIPAA Privacy Note and understand that is notice also serves as a Notice of Privacy Practices of contracted anesthesiologists utilized in the course of an office-based procedure. You have a right to restrict uses and disclosures of your health information as it pertains to treatment, payment and healthcare operations. If your restrictions are accepted, restrictions will be binding. You also understand that LIMPC or any contracted anesthesiologist is not required to agree to your requested restrictions. By initialing below, you do not request any restrictions for uses and disclosures of your health information for treatment, payment or healthcare operations at this time _____ (**INTIAL)**. You understand that you have a right to revoke this consent at anytime in writing, but if you do, your revocation will not have an effect of any actions we have already taken in reliance of this consent.

ACKNOWLEDGEMENT AS SIGNER OF THE ACCOUNT:

Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. I understand my rights and obligations as a patient of long island medical p.c. should the patient are a legal minor as defined in the state of NY Statue, I hereby attest as the signer below, that I am the lawful guardian of the minor.

All patients must Read and Sign the Following before Treatment Can Commence
ASSIGNMENT AND AUTHORIZATION

I authorize that my insurance benefits be paid directly to Long Island Medical, P.C
I acknowledge that I am responsible for full payment of services rendered. I have read the above information carefully, and agree with all the terms. I also authorize the release of any information necessary or helpful in processing the claim for reimbursement for medical services. This authorization is valid for the release of medical information to all insurance carriers. As the signer below, I attest that Long island Medical P.C has the right to maintain my signature on file for the purposes of filling claims. Additionally, my signature below will act as authorization for today's and future treatments, unless I rescind such authorization in writing.

_____

Print Name of Patient/ Guarantor on the account

_____ _____

Signature of Patient/Guarantor on the account **Date**

I authorize the staff to leave medical information pertaining to my care by the following methods:

____ YES _____ NO Home Telephone

____ YES _____ NO Home Answering Machine

____ YES _____ NO Cell Phone and Voice mail

____ YES _____ NO Work Phone and Voicemail

Please list the names of authorized people we may leave messages with:

Name: _____ Relationship: _____

Name:_____ Relationship: _____

NAME: _____

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS WITH THEIR DOSAGES AND HOW OFTEN YOU TAKE THEM:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

Pharmacy Information

New York State law requires prescriptions to be electronically submitted to your pharmacy. Please indicate where you would like your prescriptions sent.

Patient Name: _____ DOB:_____

Name of local pharmacy:_____

Pharmacy address: _____

_____

Pharmacy phone number:_____

Some insurers require "maintenance medications" (those medications which you will continue to take for months or more) to be processed through a "mail-away" pharmacy instead. Please indicate how we should process your maintenance medications:

Your mail-away ID#: _____

Mail-away pharmacy name:_____

Mail-away pharmacy address: _____

_____

Mail-away pharmacy phone #:_____

Mail-away pharmacy fax #:_____

****Please provide us with a copy of your pharmacy ID card****

_____ _____

Patient Signature Date Signed