ELK MEDICAL PLLC

SAKA A. KAZEEM, M.D., F.A.C.E, ENCU
1423 Bedford Ave • Brooklyn • NY • 11216
Tel #: (718) 773-0883 Fax #: (718) 773-3728

- ***KARISHMA SUKHDEO RPA-C***

PATIENT INFO

Patient Name ______________________________ **DOB** ___/____/____

(Last, First, Mi)

Address: ______________________________ **SS #** ________________

Street/ Apt #

____________ ________ ________

City State Zip

Home Tel #: ____________________ **Cell #:** ____________________

Email Address: ____________________ @ ____________

Emergency Name & Contact #: __________ ________ Tel#:____________________

Primary Care Physician (Name): ____________________ Tel #: ____________________

Referring Physician (Name): ____________________ Tel#: ____________________

INSURANCE INFO

Primary INS Name ____________________ **Id #** ________________

Relationship to patient (circle one): Self / Spouse / Dependent

If dependent -> Card Holder or Subscribers' Name: ____________________

Any Other INS? (Circle one): Yes / No

Secondary INS Name ____________________ **Id #** ________________

Relationship to patient (circle one): Self / Spouse / Dependent

If dependent -> Card Holder's or Subscribers' Name: ____________________

Any Other INS? (Circle one): Yes / No

Would you like access to ELK Medical Patient Portal? (Circle one): Yes / No
If yes, https://health.eclinicalworks.com/elkmedical

Please note:

Co-pays are <u>mandatory</u>. Payment in full is required <u>at the time of service</u> for ALL patients, with and without insurance.

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Consent form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996**(HIPPA)** I understand that by signing this consent form I authorize you to use and disclose my protected Health Information to carry out.

- Treatment (including direct or indirect treatment by other health
- Care provides involved in my treatment)
- Obtaining payment form third party payers (e.g. my insurance Company)
- The day-to-day healthcare operations or you practice

I have also been informed of, and given the right to review and secure a copy of your notice of privacy practices, which contains a more complete description of users and disclosures of my protected health Information, and my right under **HIPAA**. I understand that you Reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy Of the notice

I understand that I have the right to request a restriction on how my Protected health information is used and disclosed to carry out Treatment, payment and healthcare operations, but that you are not Require to agree to these requests restrictions.

I understand that I may revoke this consent in writing at anytime.
However, any use or disclosure that occurred prior to the date I revoke
This consent is not affected.

Signed this: Day____________Month___________Year_______

Print Patient Name: ____________________________________

Relationship to Patient: ______________________________

Signature: ____

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E- PRESCRIBING CONTENT FORM

E-Prescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy . Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care .E-prescribing greatly reduces medication errors and enhances patient safety.
These include:

1. Formulary and benefit transaction

Gives the prescriber information about which drugs are covered by the drug benefit plan.

2. Medication history transaction

Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events .

3. Fill status notification

Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up , or partially filled.
By signing this consent form you are agreeing that ELK Medical can request and use your prescription medication history from other healthcare providers and/ or third party pharmacy benefit payers for treatment purposes.
Understanding all of the above, I hereby provide informed consent to ELK Medical to enroll me in the E-prescribe program . I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Pharmacy's name____________________ Pharmacy's Tel:__________________
Patient Name ________________________ Today's Date ____________________
Patient or Guardian ___________________ Patient's Signature_________________