JEFFREY H. GRAF, M.D., F.A.C.C.
115 EAST 86TH STREET
NEW YORK, NY 10028

NAME_____ DATE_____

ADDRESS_____ APT#_____

CITY_____ STATE_____ ZIP CODE_____

SEX_____ OCCUPATION/EMPLOYER/SCHOOL_____

PHONE #'S: HOME_____ CELL_____ WK_____

DATE OF BIRTH_____ AGE_____ MARITAL STATUS_____

SOCIAL SECURITY NUMBER_____-_____-_____ EMAIL_____

REFERRING PHYSICIAN OR PERSON AND RELATIONSHIP_____

TYPE OF MEDICAL COVERAGE

PRIMARY INS. CARRIER NAME_____

ADDRESS_____ CITY_____ STATE ____ ZIP_____

ID#_____ GROUP#_____

SECONDARY INS. CARRIER NAME_____

ADDRESS_____ CITY_____ STATE ____ ZIP_____

ID#_____ GROUP#_____

SIGNATURE_____DATE_____

I request that payment of authorized Medicare or other insurance benefits be made directly, on my behalf, to Jeffrey H. Graf, MD for any services furnished to me by Dr. Graf or his staff. I authorize any holder of medical information about me to release to the health care financing administration of the US government of any other insurance carrier all information needed to determine these benefits or the benefits payable for related services and to secure the payment of fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. I directly assign all medical benefits to Jeffrey H. Graf MD and understand that I am financially responsible for all charges whether or not paid by insurance. *Furthermore, it is my understanding that regardless of insurance coverage, payment for service(s) rendered is my responsibility.*

AUTHORIZATION TO RELEASE RESULTS

I give my consent to the office of Dr. Graf to release and discuss any test results ordered by this office and to discuss my medical condition with the following person:

NAME_____ RELATIONSHIP_____ PHONE_____

ADDRESS_____SIGNATURE_____DATE_____

JEFFREY H. GRAF, MD
115 EAST 86TH STREET
NEW YORK, NY 10028

"ACKNOWLEDGEMENT AND CONSENT & PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION"

By signing below, I acknowledge that I have been offered a copy of Jeffrey H. Graf, MD's "Notice of Privacy Practices". I have therefore been advised of how health information about me may be used and disclosed by Jeffrey H. Graf, MD. I hereby give my consent to Jeffrey H. Graf, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Jeffrey H. Graf, MD's Notice of Privacy provides a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Jeffrey H. Graf, MD reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jeffrey H. Graf, MD Privacy Officer at 115 East 85th Street, New York, NY 10028.

With this consent, Jeffrey H. Graf, MD may use and disclose my health information to treat me and arrange for medical care, to seek and receive payment for services given to me and for the business operations of Jeffrey H. Graf, MD. Jeffrey H. Graf, MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Jeffrey H. Graf, MD may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they as marked Personal and Confidential. I have the right to request that Jeffrey H. Graf, MD restrict how uses or discloses my PHI to carry out TOP. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jeffrey H. Graf, MD may decline to treat me.

With this consent, Jeffrey H. Graf, MD may initiate a complaint to the Insurance Commissioner for any reason on my behalf. Jeffrey H. Graf MD may deposit checks received on my behalf when made out to the Policy Holder and received by this office. With my consent, Jeffrey H. Graf, MD and staff may share my email with the Center for Medical Weight Loss and/or ifxmail for email newsletter mailing and other program related matters.

Patient Name (Print):_____ Date:
Patient Signature:_____
Patients Representative and Explanation/Relationship:_____
Signature of Patients representative:_____

NOTE: A photocopy of this agreement/assignment shall be considered as effective and valid as the original.

Jeffrey H. Graf, M.D., F.A.C.C.
115 East 86th Street
New York, N.Y. 10028

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

1. We ask that you present your insurance card at each visit and before you see the Doctor. It is your responsibility to provide us with the correct information in order for us to bill your insurance.
2. If you have had a change in address, telephone number, co-payment, co-insurance or employer, you are responsible to notify the receptionist/biller so that we may update our records.
3. Co-Payments – By law, we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.
4. You will be responsible for any balance shown by your plan as your responsibility on their explanation of benefits
5. If we do not participate with your insurance, you must pay for services rendered at the time of your visit. We will then supply you with a claim form and a paid receipt in order for you to submit and receive reimbursement.
6. We may assess a 1.5% per month interest charge for your open balances of over 60 days.
7. MEDICARE – As participating providers with Medicare, we will bill Medicare for all your covered charges. If you have a supplemental insurance, we will then, as a courtesy to you, submit the supplemental charges. If payment is not received from your supplemental insurance within 45 days of submission, we will bill you directly for these amounts and you agree to forward payment to your office. Please understand that we do not have an agreement with your secondary carrier - - you do. If you do not have supplemental insurance, your portion of the balance as outlined by Medicare is your responsibility. You must also pay your Medicare deductible each year.

   Medicare Lifetime Signature on file: I request that payment of authorized Medicare benefits be made on my behalf to Jeffrey H. Graf MD for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.
8. MANAGED CARE – If we participate with your plan, we will bill your insurance directly. If you need to have a valid referral in order to see Dr. Graf, you are required to have the referral in place/in hand on the day of service. If Dr. Graf is not your PCP and you are seeing a specialist elsewhere, be aware that NO retroactive referrals will be given.

   Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Jeffrey H. Graf MD for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
9. NO-SHOW/MISSED APPOINTMENTS – you are the ones who choose the time and date of your office visit. If you know that you will not be able to make the appointment you set up, 48-hour notice is mandatory, except in an emergency. If you do not notify us in advance, cancel on the day prior to your visit or do not show-up for your appointment, you will be billed for the visit as follows: No-Show/missed/late cancellation of office visit - **$90.00** No-Show/missed/late cancellation of annual exam or extended visit - **$150.00.** If we call you to confirm your appointment, we do so solely as a courtesy reminder. Whether we reach you or not, it does not release you from the obligations just described.
10. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

Thank you for taking the time to review our policies. Please ask if you have any questions or special concerns.

I have read and have a full understand of this financial policy and agree to the terms.

Patient's Name: _____ Signature: _____ Date: _____

Responsible Party name, signature and relationship if other than patient _____ Date: _____

Credit Card Payment Authorization Consent Form

I authorize **Jeffrey H. Graf, MD** to keep my signature on file and to charge my credit card (MasterCard, Visa, Discover, American Express or other that I have provided) for either:

- Balance of charges not paid by insurance (those that are my responsibility) within 90 days, or
- Balances that are my responsibility (i.e. deductibles, co-payments, co-insurance, etc.) as soon as they are due.

These charges will apply to all visits unless the following item is checked:

___ this visit only

I am aware that use of my credit card will include an addition fee of approximately 3.99% per charge.

I assign my Insurance benefits to the provider listed above. I understand that this form is valid for one year and will automatically renew unless I cancel the authorization through written notice to the health care provider.

Patient Name: _____

Cardholder Name: _____

Cardholder Billing Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Expiration Date: _____

Cardholder Signature: _____

Date: _____