CARE ONE MULTISPECIALTY

REGISTRATION FORM

Last Name (Apellido) _____ First Name (Nombre) _____

Address (Direccion)_____ Apt_____

City (Ciudad) _____ State (Estado) _____ Zip Code (Codigo Postal) _____

Date of Birth (Fecha De Nacimiento) _____ Sex (Sexo) M / F

Social Security (Seguro Social) _____

Phone Numbers (Numeros de Telefono)

Home (Casa) _____

Cell (Celular) _____

Work (Trabajo)_____

JOIN OUR PATIENT PORTAL!!!!

Email Address (Coreo Electronico) _____

Emergency Contact (Contacto de Emergencia)

Name: _____

Relationship: _____

Phone Number: _____

Reason for your visit (Razon de su visita): _____

Insurance Information (Informacion de Seguro Medico)

Primary Insurance (Seguro Primario): _____

Member ID # (ID de Miembro): _____

Relationship to the Insured (Relacion al Asegurado): _____

Secondary Insurance – if applicable (Seguro Secundario – si applica): _____

Member ID # (ID de Miembro): _____

Relationship to the Insured (Relacion al Asegurado): _____

Pharmacy Name: _____

Pharmacy Address: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent CARE ONE MULTISPECIALTY to use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____.

Print Name of Patient or Legal guardian: _____ Date: _____

Signature of Patient or Legal Guardian: _____ Date : _____

Witness: _____ Date : _____

Loving Care Medical/Care One Multispecialty
132-03 120th Ave
South Ozone Park, NY 11420

PATIENT RESPONSIBILITY

PATIENT NAME: _____ DOB: _____

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- Co-payments are due at time of service.
- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for or the balance in full.
- **I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.**

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to LOVING CARE MEDICAL on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

- I hereby authorize LOVING CARE MEDICAL to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE BENEFICIARIES**

- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in LOVING CARE MEDICAL. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed To determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative/ Responsible Party Date

_____ _____

Print name of Patient, Authorize Representative/ Responsible Party Relationship to Patient