Eastside Medical Associates
111 East 88TH Street
Suite 1A
New York, NY 10128

AMY D. LICHTENFELD

JEFFREY M. LORIA, MD

PATIENT INFORMATION

PLEASE PRINT

NAME _____ (LAST NAME) _____ (FIRST NAME) _____ (MI) SEX **M**

BIRTHDATE _____ SOC. SEC. NUMBER _____ EMAIL _____

ADDRESS _____ APT. NUMBER _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____

IS IT OKAY TO LEAVE A MESSAGE? ☐ YES ☐ NO

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ MINOR (UNDER 18 YRS)

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE _____

WHO SHOULD WE THANK FOR REFERRING YOU? _____

PRIMARY PHYSICIAN NAME _____ PHONE _____

PRIMARY INSURANCE

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____ SOC. SEC. NUMBER _____

INSURANCE COMPANY NAME _____ POLICY EFFECTIVE DATE _____

SUBSCRIBER NUMBER _____ GROUP NUMBER _____

ADDITIONAL INSURANCE (IF APPLICABLE)

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

POLICY HOLDER NAME _____ SEX ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____ SOC. SEC. NUMBER _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY NAME _____ POLICY EFFECTIVE DATE _____

SUBSCRIBER NUMBER _____ GROUP NUMBER _____

AUTHORIZATION AND RELEASE

I AUTHORIZE THIS RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AGREE TO BE RESPONSIBLE FOR ANY NON-COVERED FEES, COPAYMENTS, COINSURANCE. AND DEDUCTIBLES.

SIGNATURE OF PATIENT _____ DATE _____

Eastside Medical Associates
111 East 88th Street
Suite 1A
New York, NY 10128
212-288-2278

PATIENT FINANCIAL WAIVER

We appreciate you choosing our practice **Eastside Medical Associates,** for your medical care, and we want to clearly state our policies regarding payment for any care. If you have any questions on the following, don't hesitate to bring them up with us.

Eastside Medical Associates have agreed to be providers with your insurance. Depending on your particular contract, certain services may or may not be covered by your insurance carrier. It is important for you to consult with your insurance carrier before your visit to determine which services are covered.

Any expenses that your insurance carrier does not cover are your financial responsibility. Be sure you understand and agree to the following:

I understand that charges not covered by my insurance company, as well as applicable co-payments, co-insurances and deductibles are my responsibility. I also understand that in the event of non-payment or partial payment from my insurance company, I am responsible for any unpaid balances. I realize failure to keep my account current may result in **Eastside Medical Associates,** being unable to provide additional services. In case of default on payment of this account, I agree to pay a processing fee and attorney fees incurred to collect on any outstanding balances due to non-payment.

If for any reason you are not able to meet your financial obligations, please feel free to contact our billing department. Our billing department is open from **9:00 a.m. to 5:00 p.m., Monday — Friday.**

I authorize insurance benefits that are payable to me or my assignee, to be paid directly to **Eastside Medical Associates,**

I authorize **Eastside Medical Associates,** to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

I have read, understand and agree to the above Financial Policy.

Print name of patient _____

Signature of patient _____

Date _____

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(212)-288-2278

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I,**AB CD** , hereby authorize Eastside Medical Associates, P.C. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identity me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Eastside Medical Associates, P.C. can refuse to treat me.

I have been informed that Eastside Medical Associates, P.C. has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Eastside Medical Associates, P.C. In writing, but if I revoke my consent, such revocation will not affect any actions that Eastside Medical Associate, P.C. took before receiving my revocation.

I understand that Eastside Medical Associate, P.C. has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Eastside Medical Associates, P.C. restricts how my individually Identifiable health information Is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Eastside Medical Associates, P.C. does not have to agree to such restrictions, but that once such restrictions are agreed to, Eastside Medical Associates, P.C. must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative
(Form MUST be completed before signing.)

Date

_____

Printed name of patient or patient's respresentative

_____

Relationship to patient