Allergy, Asthma & Sinus Center of Long Island
Harshit M. Patel , M.D.
120 Bethpage Road, Suite 310, Hicksville, NY 11801 - 3227 Long Beach Rd., Oceanside, NY 11795
820 Suffolk Avenue, Brentwood, NY 11717 - 431 Beach 129th Street, Belle Harbor, NY 11694
373 W. Main Street, Babylon, NY 11702 - 124 East 40th Street, Ste 404, Manhattan, NY 10016
Tel#: (516) 822-6655 o Fax #: (516) 932-2090

Personal Information

*Name: _____
Last First MI

*Address: _____
Street

_____
City State Zip

*Social Security #: _____ - _____ - _____

Age: ____ *Date of Birth: ___/___/___ *Sex: Male Female

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: _____

*In Case of Emergency Notify: _____

*Relation: _____ Emergency Phone: _____

*Referring Physician: _____

*Primary Physician: _____

*Physician Phone: _____

Parent/Legal Guardian Information

Social Security #: _____ - _____ - _____

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip

Driver's License: _____

Age: _____ DOB: ____ /____/____ Sex: Male Female

Home Phone : _____

Work Phone: _____

Mobile Phone: _____

Relationship: Mother Father Guardian Other: _____

Primary Insurance Information

Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

*Subscriber's Name: _____

*Subscriber's SSN: _____ - _____ - _____

*Relationship: Self Parent Guardian Spouse Other: _____

*Subscriber's DOB: ____ / ____ / ____

Subscriber's Effective Date: ____ /____ /_____

*Policy Number: _____

*Group Number: _____

Subscriber's Employer: _____

Employer's Address:

_____
Street

_____
City State Zip

Employer's Phone #: _____

Secondary Insurance Information

*Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

*Subscriber's Name: _____

*Subscriber's SSN: _____ - _____ - _____

*Relationship: Self Parent Guardian Spouse Other: _____

*Subscriber's DOB: ____ / ____ / ____

Subscriber's Effective Date: ____ / ____ / ____

*Policy Number: _____

*Group Number: _____

Subscriber's Employer: _____

Employer's Address:

_____
Street

_____
City State Zip

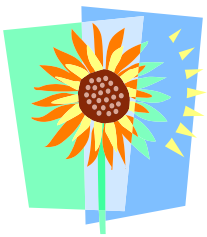
Employer's Phone #: _____

Whom may we thank for referring you?

- ☐ Physician Office : _____
- ☐ Relative or Friend: _____
- ☐ Insurance Provider Directory
- ☐ Yellow Pages
- ☐ Other: _____

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

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



Consent and Disclosures Form

Harshit Patel, M.D.

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The following two pages outlines our billing policies, authorization for treatment, assignment of benefits, release of medical information, and our privacy policies to comply with the Health Insurance Portability and Accountability Act (HIPPA).

Billing

- I (patient, parent, or legal guardian) understand that if the current insurance information is not received at the time of service, I will be responsible for full payments at the time of services are rendered.
- If I am a self-pay patient, I am financially responsible for all services received and that payment is expected at time service is rendered.
- In the situation of third part financial responsibility to cover the cost of your visit, the primary and ultimate responsibility for payment rests with you (patient, parent, or legal guardian).
- We are contracted with a number of managed care plans (**P**referred **P**rovider **O**rganizations, **H**ealth **M**aintenance **O**rganizations, and **I**ndependent **P**hysician **A**ssociations). We must follow the terms of these plans including their financial relationships and **mandatory co-payments** and **deductibles**, which are required at time service is rendered.
- There will be a billing service fee of $10.00, if **mandatory co-payments** and **deductibles** are not paid at the time of service.
- There will be a $20.00 fee for each **bounced check**.
- In result of a non paid outstanding balance, your account balance will be forwarded to a **collection agency** and we will charge a $50.00 collection fee.
- In regards to federal programs (Medicare and New York Medicaid), we have agreed to accept as full payment the government's discounted payment schedule. You are responsible for any **mandatory co-payments and deductibles** at the time of service (although you may have supplemental co-insurance which may cover the co-payment).
- I (patient, parent, or legal guardian) understand that it is my responsibility of bringing in a **valid referral** at the time of services rendered. If not, I will be fully responsible for the services rendered.
- This office confirms appointments as a courtesy; it is your responsibility to keep your appointment. If you are not able to keep your schedule appointment, please give us 24 hours notice. Missed Appointment Charge/NO SHOW CHARGE $25.00 (NOT APPLIED TO ALLERGY SHOT PATIENTS).

Authorization for Treatment

I hereby voluntarily consent to medical care for the above names patient encompassing diagnostic procedures and medical treatment by the physician, his/her assistants, or designees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

Assignment of Benefits

I hereby assign to Harshit M. Patel, M.D., P.C. all rights, title, and interests in the benefits payable to me by an insurance policy (ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance.

_____ _____ - _____ - 20____
Signature of Patient/Parent/Legal Guardian Date

Notice of Privacy Practices

Harshit Patel, M.D.
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Notice of Privacy Practices

The Health Insurance Portability & Accountability Act ("HIPPA") is a program allows significant rights to understand and control how your health information is used. "HIPPA" provides penalties that misuse personal health information. The following describes how we may use your information.
I authorize Harshit M. Patel, M.D., P.C. to use and disclose personal medical information for each of the following purposes: treatment (i.e., among health care providers), payment (i.e. insurance companies), and health care operations (i.e. internal quality control). Dr. Patel may release medical information to the insurance carrier, Social Security Administration, third party administrators, referring physician, or any party that may be liable for all or part of medical charges information as may be necessary for the purpose of enabling the determination of benefits available to the patient for the services rendered during this period of care. Dr. Patel may also create and distribute de-identified health information by
removing identifiable information. Any other uses and disclosures will be made only with written authorization. You may revoke such authorization in writing, except to the extent that we have already taken actions relying on your authorization.
I authorize Harshit M. Patel, M.D., P.C. to release information to our selected medical institutions and hospitals for laboratory, audiological, radiological, surgical, allergic, or other ancillary medical services as may be necessary for the purpose of scheduling, billing, or determination of benefits available to the patient for the services rendered during this period of care.

- We may contact you to provide appointment reminders or health-related benefits that may be of interest to you.
- I understand that the requester may not further use or disclose the medical information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.
- I understand that I have a right to inspect or receive a copy of this authorization, an account of disclosures of my health information, or my personal health information upon my request.
- I understand that billing statements and correspondence from our office will be sent to the address listed on the previous page.
- I understand that confidential messages (i.e. appointment reminders) may be left on your home answering machine or voice mail at the phone numbers listed on the previous page (home, work, or mobile phone numbers) unless you request us not to.
- I understand that diagnosis or treatment of me by Harshit Patel, MD may be conditioned upon my consent as evidenced by my signature on this document.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, including those related to disclosures to family members, other relatives, friends, or anyone identified by you. Harshit Patel, MD is not required to agree to the restrictions that I may request. However, if Harshit Patel, M.D. agrees to a restriction that I request, the restriction is binding on Harshit M. Patel, M.D., P.C.
- I have the right to revoke this consent, in writing, at any time, except to the extent that Harshit M. Patel, M.D., P.C. has taken action in reliance on this consent.
- I understand I have a right to review Harshit M. Patel, M.D. Notice of Privacy Practices prior to signing this document. The Harshit Patel, M.D. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Harshit M. Patel, M.D., P.C.
- Harshit Patel, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
- This authorization shall become effective immediately and shall remain in effect for 2 years.
- I understand that you have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint to our office, the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I also authorize the following relatives, friends, or other people that may be informed about my general medical condition or diagnosis:

Name: _____ Name: _____

_____ _____ - _____ - 20__
Signature of Patient/Parent/Legal Guardian Date