GOTHAM MEDICAL ASSOCIATES

LAST NAME: _____ **FIRST NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **MOBILE:** _____

DATE OF BIRTH: _____ /_____/_____ **FEMALE ( ) MALE ( )**

SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____

MARITAL STATUS: S M DP W D SEP **RACE:** _____

EMPLOYER: _____ **WORK TEL:** _____

EMERGENCY CONTACT PERSON: _____ **RELATIONSHIP:** _____
FIRST NAME LAST NAME

EMERGENCY CONTACT TELEPHONE: _____

PRIMARY INSURANCE: _____

ID#: _____ **GROUP#:** _____

SUBSCRIBER'S NAME AND RELATIONSHIP: _____ **SUBSCRIBER'S DOB:** _____ /_____/_____

SECONDARY INSURANCE: _____

ID#: _____ **GROUP#:** _____

PHARMACY NAME: _____ **TEL:** _____ **FAX:** _____

PHARMACY ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

TEL: _____ **FAX:** _____

REFERRING PHYSICIAN: _____

ADDRESS: _____

TEL: _____ **FAX:** _____

X _____ _____
Patient Signature **Date**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize **Gotham Medical Associates, PLLC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I authorize the release of medical information to the insurance carriers in order to process my insurance claim acquired in the course of my examination or treatment and to allow a photocopy of my signature to be used for my insurance claim for the period of lifetime. I understand that while this consent is voluntary, if I refuse to sign this consent, **Gotham Medical Associates, PLLC** can refuse to treat me.

I have been informed that **Gotham Medical Associates, PLLC** 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 **Gotham Medical Associates, PLLC**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Gotham Medical Associates, PLLC** took before receiving my revocation.

I understand that **Gotham Medical Associates, PLLC** has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Gotham Medical Associates, PLLC** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Gotham Medical Associates, PLLC** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Gotham Medical Associates, PLLC** must adhere to such restrictions.

_____ (Patient's Initials) **Medicare Patients:** I authorize release of my medical information to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Gotham Medical Associates**.

_____ _____

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

_____

Printed name of patient or patient's representative

_____

Relationship to the patient

CONSENT TO TREATMENT

I, _____, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed topical anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I understand this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

CONSENT FOR ELECTRONIC COMMUNICATION

I, _____, agree to communicate via e-mail or electronic messaging through the Gotham Medical Associates practice website on matters related to my own health and / or medical treatment. I understand that any confidential health information that I send to the practice will be handled in strict accordance with the Gotham Medical Associates Privacy Policy but that it is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for the breach of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any confidential health information I request to be sent to me via e-mail. Because this information is not encrypted, I understand that it is not secure, I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

SIGNATURE_____ **DATE**_____

PRINT NAME_____

GOTHAM MEDICAL ASSOCIATES

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby assign all medical, surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers or health plan, including the Health Care Financing Administrator and its intermediaries, to issue payment directly to the physician for services rendered to me or my dependents regardless of my insurance benefits, if any.

I have requested medical services on behalf of any dependents or myself and I understand that by making this request I become financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL RESPONSIBILITY AND POLICY

All professional services rendered are charged to the patient and are due at time of service, unless other arrangements have been made in advance, with our billing department. We will assist you with the claims process and work with you to resolve any issues pertaining to your insurance coverage and reimbursement for services. However, you are ultimately responsible for all fees, regardless of your insurance coverage.

For those insurance plans that our physicians participate with, we will bill the health plan or insurance carrier directly for you according to the terms of your coverage and our participation with the specific plan. You remain financially responsible for all copayments, coinsurance, deductibles and non-covered services. In addition, it is the patient's responsibility to abide by the insurance plan requirements for obtaining precertification and referrals prior to receiving services.

NO SHOW/CANCELLATION POLICY

Gotham Medical Associates strives to provide prompt and timely care for all patients. We would like to maintain availability for our patients, and appointment "no shows" or late cancellations hinder our ability to provide care. As such, cancellations are required no later than 24 hours prior to your scheduled appointment. Patients who do not cancel at least one day prior to their appointment or do not show for an appointment will be charged $75 for an office visit and $175 for a procedure.

SIGNATURE_____ **DATE**_____

PRINT NAME_____