**Hillside Polymedic Diagnostic and Treatment Center**
**Patient Intake Form**

**Date: _____**

## Patient Information:

First Name: _____ M.I._____ Last Name: _____
Address: _____ Apt. No. _____ City_____ State: ____ Zip: _____
Phone: Home: _____ Cell: _____ Work: _____
Email: _____ SSN: _____
DOB (00/00/0000): _____ Sex: [ ] Male [ ] Female [ ] Other

**Marital Status**: [ ] Single [ ] Married [ ] Divorced [ ] Annulled [ ] Domestic Partner [ ] Widowed

**Race**: [ ] White
[ ] Black/ African American
[ ] Asian
[ ] Native Hawaiian/ Other Pacific Islander
[ ] Other: _____
[ ] Declined to Specify/ Unknown

**Ethnicity**: [ ] Hispanic/Latino
[ ] Not Hispanic/Latino
[ ] Declined to Specify/Unknown
[ ] None

**Primary Language**: _____ **Secondary Language**: _____
**Communication Needs**: [ ] None [ ] Deaf [ ] Mute [ ] Blind [ ] Nonverbal

**Emergency Contact:**
Name: _____ Contact Number: _____ Relationship: _____

**Pharmacy Information:**
Pharmacy Name: _____ Pharmacy Tel.: _____
Pharmacy Address: _____

**Employment Information:**
Employer: _____ Occupation: _____
Address: _____ Tel: _____
**Student:** [ ] Fulltime [ ] Part time [ ] Not Student

**Insurance Information:**
Primary Insurance Carrier: _____
Insurance ID #: _____ Group/Plan: _____
Insured Name: _____ Insured DOB: _____

Secondary Insurance Carrier: _____
Insurance ID #: _____Group/Plan: _____
Insured Name: _____ Insured DOB: _____

**Hillside Polymedic Diagnostic and Treatment Center**
**187-30 Hillside Avenue, Jamaica, NY 11432**
**Tel: 718-264-1111 Fax: 718-264-9125**

# CANCELLATION AND NO SHOW POLICY

We understand that situations may arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment that you provide us 24 hours' notice: This will enable another person who is waiting for an appointment to be scheduled on the appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people. Below is our policy for appointments not kept:

For appointments cancelled more than 24 hours prior to scheduled time: **NO FEE**

For appointments cancelled less than 24 hours prior to scheduled time: **$25.00 FEE**

For those who do not show up for their appointments and do not cancer: **$25.00 FEE**

For patients who call less than 5-6 hours prior to scheduled time: **$25.00 FEE**

**FOR PATIENTS WHO OWE CANCELLATION AND/OR NO SHOW CHARGES WILL BE REQUIRED TO PAY THE NO SHOW/CANCELLATION FEE PRIOR TO BEING SEEN AGAIN.**

**CHARGES THAT REMAIN DELINQUENT WILL ULTIMATELY BE SENT TO COLLECTION.**

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand the certain special unavoidable circumstance may cause you to cancel in less than 24 hours. Fees in this instance may be waived but only with approval from management. Our practice firmly believes that good physician-patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 718-264-1111.

**Please sign that you read, understood and agreed to this Cancellation and No-show Policy.**

**Patient Name: (Please Print) _____**

**Date of Birth: _____**

**Signature of Patient or Patient Representative: _____**

**Today's Date: _____**

# HILLSIDE POLYMEDIC DIAGNOSTIC AND TREATMENT CENTER

## FINANCIAL POLICY

Hillside Polymedic D & TC wants to provide out community with healthcare services and, at the same time, keep costs under control. To do this, we need your help. We ask you to read our payment policy listed below:

- **Your bill is based on the services you receive. You are responsible for paying the bill if your insurance company does not cover all the costs.**
- **What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.**
- **You need to contact your insurance company with any questions about what they will cover.**
- **We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at 718-264-1111 at once so we can help you with this problem. Hillside Polymedic D & TC will help you to arrange a payment plan. If there is a need, we will help you to apply for Medical Assistance.**

## IF YOU DO NOT HAVE MEDICAL INSURANCE

**Your Responsibility**

- You must pay your entire bill at the time of service or inform us of your inability to pay.

**Our Responsibility**

- Hillside Polymedic D & TC will provide the services you need, even if you cannot pay. We will not provide services if you are able to pay but choose not to pay.
- We are willing to talk to you about ways to pay, if you cannot pay the full amount.

## IF YOU HAVE HEALTH INSURANCE

We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your employee health benefits.

## IF WE DO PARTICIPATE IN YOUR INSURANCE PLAN (including Medicare)

**Your Responsibility**

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service
- You must pay the amount not paid by your insurance within 18 days of getting your bill, except for those from whom Hillside Polymedic D & TC cannot collect by law or agreement. If you do not pay, we will begin collection efforts.

**Our Responsibility**

- We will send a bill to your insurance company for all the services done in our offices.

## IF WE DO NOT PARTICIPATE IN YOUR INSURANCE PLAN

**Your Responsibility**

- You must pay for the services at the time it is given to make it simple, our office accepts cash, flexcard from the insurance (Visa, Mastercard and Discover)

**Our Responsibility**

- After you have paid us, we will send your bill to your insurance company. Your insurance company will then pay you.

## STATEMENT OF FINANCIAL RESPONSIBILTY

The patient who receives care and treatment from Hillside Polymedic D & TC must pay any charges that are not paid by insurance or any other party.

Other providers, such as x-ray, laboratory, will bill the patient separately.

The patient must pay any amount not paid by insurance within eighteen (18) days of receiving the bill. If Hillside Polymedic D & TC needs to use a collection agency or attorney to collect the unpaid amount, the patient may be charged for all the fees and costs to Hillside Polymedic D &TC by the agency or attorney.

**Please sign that you read, understood and agreed to our Financial Policy.**

**Patient Name: (Please Print) _____**

**Date of Birth: _____**

**Signature of Patient or Patient Representative: _____**

**Today's Date: _____**

**NEW YORK STATE OUT-OF-NETWORK SURPRISE MEDICAL BILL ASSIGNMENT OF BENEFIT FORM**

Use this form if you receive a surprise bill for health care services and want the services to be treated as in-network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

**A surprise bill is when**:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from an non-participating physician instead of from an available participating physician; **OR**

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

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**I assign my rights to payment to my provider and I certify to the best of my knowledge that:**
I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any co-payment, co-insurance or deductible that would be owed if I or my dependent used a participating provider. If any insurer paid me for the services, I agree to send the payment to my provider.

**Your name:** _____

**Your Address:** _____

**Insurer Name:** _____

**Your Insurance ID No.:** _____

**Provider Name:** _____ **Provider Tel. No.:** _____

**Provider Address:** _____

**Date of Service:** _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

(Signature of patient) (Date of signature)

**HILLSIDE POLYMEDIC DIAGNOSTIC AND TREATMENT CENTER**
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## Consent for Use and Disclosure of Health Information
## HIPAA Notice of Privacy Practices

I believe that your health insurance information is personal. I keep records of care and services that you receive at my office. I am committed to keeping your information private and I am also required by law to respect your confidentiality. I will use your information which you have supplied for the following purposes:

- To provide the best possible treatments you require.
- To request payments from your insurance carriers.
- To contact you regarding your appointments and coordination of appointments with other health providers.

**SECTION A: PATIENT GIVING CONSENT**
**Name: _____**
**Address: _____**
**Telephone No.: _____**

**SECTION B: TO THE PATIENT, PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:**
Purpose of consent B: By signing this form you will consent to my use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read out Notice of Privacy Practices before you decide whether to sign the consent. Our notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. I encourage you to read it carefully and completely before signing this consent.

We reserve the right to change out privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting us at the above address.

**Rights to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the above address. Please understand that revocation of the consent will not affect any action we took in reliance on this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____ (last name, first name) have had full opportunity to read and consider the contents of this consent form and your disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature: _____ Date: _____**

If a personal representative on behalf of the patient signs this consent, complete the following:
**Personal Representative's Name: _____**
**Relationship to Patient: _____**

**Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDSrelated Information**

**NEW YORK STATE DEPARTMENT OF HEALTH**

| Patient Name | Date of Birth | Patient Identification Number |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.

2. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3664. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address or Provider to Whom this Information Will Be Disclosed:
**Hillside Polymedic Diagnostic and Treatment Center 187-30 Hillside Avenue, Jamaica, NY 11432 Tel: 718-264-1111, Fax: 718-264-9125**

7. Purpose for Release of Information:

8.
Unless previously revoked by me, the specific information below may be disclosed from: _____until _____

insert start date insert expiration date of event

[ ] All health information (written and oral), except:

_____

_____

| For the following to be included, indicate the specific information to be disclosed and initial below. | |
|---|---|
| [ ] Records from alcohol/drug programs | |
| [ ] Clinical records from mental health programs* | |
| [ ] HIV/AIDS-related Information | |

| 9. If not the patient, name of person signing form: | 10. Authority to sign on behalf of patient: |
|---|---|
| | |

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

**Witness Statement/Signature**: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____

STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of redisclosure.
*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.