ORTHOMANHATTAN
485 MADISON AVENUE, 8TH FL
NEW YORK, NEW YORK 10022

PATIENT INFORMATION

[Please fill in or correct in the appropriate section]

PATIENT NAME: ______________________

DATE OF BIRTH: ______________________

ADDRESS: ______________________

CITY:__________STATE:________ZIP:__________

PATIENT SOCIAL SECURITY #:______________________

HOME PHONE:______________________

WORK PHONE:______________________

MOBILE PHONE:______________________

EMAIL: ______________________

REFERRING PHYSICIAN:______________________

PRIMARY CARE PHYSICIAN:______________________

OCCUPATION:______________________

EMPLOYER'S NAME:______________________

EMERGENCY CONTACT:

NAME:______________________

CONTACT #:______________________

RELATIONSHIP:______________________

INSURANCE INFORMATION

PRIMARY INSURANCE:______________________

MEMBER ID#______________________

GUARANTOR:______________________

GUARANTOR DOB:______________________

GUARANTOR SS#______________________

SECONDARY INSURANCE: ______________________

MEMBER ID: ______________________

WORKER'S COMPENSATION OR NO FAULT

DATE OF ACCIDENT:______________________

INSURANCE CO. NAME:______________________

INSURANCE PHONE: ______________________

POLICY #:______________________

INSURANCE REP:______________________

CASE#: ______________________

MY APPOINTMENT TODAY IS WITH (PLEASE CHECK):

- o O. ALTON BARRON, MD
- o LOUIS W. CATALANO III, MD
- o ADAM B. COHEN, MD
- o STEVEN Z. GLICKEL, MD
- o JONATHAN R. STEIBER, MD

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign OrthoManhattan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize OrthoManhattan to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

SIGNATURE: ______________________ DATE: ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, have been informed that the U.S. Government requires I sign this *Notice of Privacy Practices.* The privacy regulations were created by the *HIPPA Act of 1996* to protect patient privacy. I understand that the full text of the Act is available to me upon request.

SIGNATURE: ______________________ DATE: ____________

CANCELLATION POLICY

I, the undersigned, understand that as a patient at OrthoManhattan I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a **$50 cancellation fee.**

SIGNATURE: ______________________ DATE: ____________

WORKERS' COMPENSATION ONLY

You may become responsible for the medical costs of treatment for you illness or condition with the provider listed above if (1) you fail to prosecute the claim for workers' compensation or (2) It is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law **§**32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered**. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment. NY-WCB A9 (1-07)**

SIGNATURE: ______________________ DATE: ____________

MEDICARE PATIENTS ONLY

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to OrthoManhattan for services furnished to me by OrthoManhattan. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: ______________________ DATE: ____________