PATIENT INFORMATION

ACCT#________________

PATIENT'S NAME: ________________________ DATE OF BIRTH: ________________

STREET ADDRESS: ________________________ APT.#:__________ CITY:________________

STATE: ____ ZIP CODE:_______ PH #:___________ CELL#___________ WORK#___________

SEX: M___ F___ AGE: ____ SOCIAL SEC. #:____-___-____ MARITAL STATUS: S___M___D___W___

EMAIL______________________________ **I WOULD LIKE TO BE ENROLLED IN THE PATIENT PORTAL YES NO**

RACE: __________ **ETHNICITY:** ____ **NON-HISPANIC OR LATINO** ____ **HISPANIC OR LATINO**

PREFERRED LANGUAGE ______________

SPOUSE'S NAME: ______________________ SPOUSE'S DATE OF BIRTH:__________ SPOUSE'S SSN:____-___-____

EMERGENCY CONTACT: ____________________ EMERGENCY CONTACT#:_______________ **HIPAA APPROVED YES NO**

PARENT'S NAME (IF CHILD):___________________________ PARENT'S SSN:____-___-____

PATIENT'S EMPLOYER (PARENT'S EMPLOYER IF CHILD):____

IS THIS WORKER'S COMP.: YES____ NO____ IS THIS NO FAULT: YES____ NO____

DO YOU HAVE A PRIMARY CARE PROVIDER? ___ YES ___ NO NAME OF PRIMARY CARE PHYSICIAN_____________________

PRIMARY PHYSICIAN ADDRESS: ______________________________ PHONE #:____________________

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: __________________________________

POLICY ID #:________________ GROUP #:____________________

POLICY HOLDER'S NAME: ______________________________ RELATIONSHIP TO PATIENT:___________

DOB: _______ SS#:____-____-_____ POLICY HOLDER'S EMPLOYER____________________________________

EMPLOYER ADDRESS: ____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME: __________________________________

POLICY ID #:________________ GROUP #:____________________

POLICY HOLDER'S NAME: ______________________________ RELATIONSHIP TO PATIENT:___________

DOB: _______ SS#:____-____-_____ POLICY HOLDER'S EMPLOYER____________________________________

EMPLOYER ADDRESS: ____

111 Maltese Dr. Middletown, NY 10940 · 845-342-4774 Phone · 845-343-6116 Fax
www.middletownmedical.com

PATIENT CONSENT FOR EXTERNAL PRESCRIPTION HISTORY

I, ______________________, whose signature appears below, authorize Middletown Medical, PC and Its Affiliated Providers to view my external prescription history via the Rx Hub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

______________________________ ______________

Patient **Date**

PATIENT CONSENT/ ACKNOWLEDGEMENT

CHARGES FOR SERVICES RENDERED: All charges for office services are due at the time of my visit to Middletown Medical, PC. If an insurance claim is filed by Middletown Medical, PC, I request that payment of all benefits be made on my behalf to Middletown Medical, PC.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

Notice Of Privacy Practices I acknowledge that I have r been provided with a copy of Middletown Medical's Notice of Privacy Practices

SHARING/DISCLOSING HEALTH INFORMATION: I acknowledge that I have received Middletown Medical P.C. Notice of Practices. I authorize Middletown Medical, PC to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPPA (i.e., related to treatment, payment, or healthcare operations). I further authorize Middletown Medical, PC to gain access to medical records with information relevant to my treatment from any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

TREATMENT: I further authorize and consent to Middletown Medical, PC's physicians and their assistants and other professional staff providing medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

EMERGENCY MEDICAL CARE: In the event that a life-threatening emergency occurs while I am in attendance at Middletown Medical, PC in which emergency medical care or treatment is required, I hereby authorize Middletown Medical, PC and its related providers to arrange for the care and treatment necessary to address my emergency medical condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment and I agree to be responsible for all medical and related costs associated with such emergency and follow-up medical treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier and/or health care plan to make payment to Middletown Medical, PC and hereby assign to Middletown Medical, PC any and all rights, title and interest I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by Middletown Medical, PC, its physicians and their assistants and other professional staff providing medical treatment, supplies, services, equipment and other items. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to Middletown Medical, PC for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or on my behalf. If, for whatever reason, my insurance company and/or health care plan should remit payment directly to me for any medical treatment, supplies, services, equipment or other items rendered to me by Middletown Medical, PC, I shall promptly endorse the check to Middletown Medical, PC and mail to the address below. Checks received by Middletown Medical, PC with joint payees, shall be endorsed to Middletown Medical, PC within five (5) days. In the event that I should cash a check received by me, which is intended as payment to Middletown Medical, PC for services rendered, and retain the proceeds for personal use, I understand I will be subject to 1% interest per month (calculated on the total amount due), all legal costs and termination of treatment through Middletown Medical, PC. **IF NO PAYMENT IS RECEIVED WITHIN SIXTY DAYS, MIDDLETOWN MEDICAL, PC HAS THE RIGHT TO TURN MY ACCOUNT OVER TO COLLECTION. ALL LEGAL COSTS INCURRED WILL BE MY RESPONSIBILITY.**

______________________________ ______________________________

Signature of Patient / Parent / Legal Guardian **Date**

______________________________ ______________________________

Name of Patient / Parent / Legal Guardian **Relationship to Patient**

____

Patient's Name (if signed by Parent or Legal Guardian)

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AUTHORIZATION: COMMUNICATION OF CONFIDENTIAL INFORMATION

45 CFR §164.506(b)(1)

In order to effectively communicate with you regarding your medical treatment and health information, we request that you complete this form, to authorize those means of communication which provide the best ways for us to communicate with you regarding your confidential information. We may need to communicate with you about billing information, appointment information and medical / health information including, but not limited to lab test results, x-ray results, prescription information, diagnostic information or to otherwise respond to requests or messages left for your physician. We have the ability to communicate with you using the below methods, and will do so, based on your authorization, as indicated below.

Please check each of the boxes that you give Middletown Medical, PC permission to use for your communications:

☐ You may contact me by telephone ☐ You may leave a message / voicemail*	Phone Number(s): ______ Phone Number(s): ______
☐ You may contact me by mail	
☐ You may contact me through email / my patient portal	

*** I authorize Middletown Medical, PC, its physicians and employees to leave detailed messages specific to my medical care including test results on the phone number(s) listed above. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access.**

If you would like to grant permission for Middletown Medical, PC to communicate your confidential information to anyone besides you, please provide their details below, including what type of information (in the "Options" column) you would like us to be able to share with the listed individuals:

Name	Phone Number	Relationship	Options
			☐ Billing Information ☐ Appointment Information ☐ Medical / Health Information
			☐ Billing Information ☐ Appointment Information ☐ Medical / Health Information
			☐ Billing Information ☐ Appointment Information ☐ Medical / Health Information
			☐ Billing Information ☐ Appointment Information ☐ Medical / Health Information

This authorization supersedes any prior "AUTHORIZATION: COMMUNICATION OF CONFIDENTIAL INFORMATION" I may have completed.

I understand that this authorization can be revoked at any time by submitting a written request to Middletown Medical, PC. Unless revoked sooner, this authorization will expire one (1) year from the date listed above.

______________________________ ______________________________

Signature of Patient / Parent / Legal Guardian **Date**

______________________________ ______________________________

Name of Patient / Parent / Legal Guardian **Relationship to Patient**

____

Patient's Name (if signed by Parent or Legal Guardian)

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