Patient's Full Name- DOB-

REGISTRATION FORM TODAY'S DATE _____

Patient's Social Security # _____ Date of Birth _____ Sex _____

Marital Status (Check One) ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Address _____
Street Apt# City State Zip

Home Telephone _____ Cell phone _____

E-mail Address: _____

Primary Care Physician _____ Phone _____

Pharmacy_____**Phone** _____

Patient's Occupation _____ Patient's employer _____

Patient's Employer Address _____ Phone _____

Name of Patient's Spouse _____Spouse's employer _____ Phone _____

**If patient is a MINOR, fill in responsible parent or guardian:*

Mother's Name _____ *Mother's Employer* _____

Mother's Date of Birth _____ *Social Security #* _____ *Work Phone* _____

Father's Name _____ *Father's Employer* _____

Father's Date of Birth _____ *Social Security #* _____ *Work Phone* _____

Father's Address _____

Have you or anyone in your family been a patient of the Doctor? ☐ YES ☐ NO

Who? _____ Relationship _____

Whom may we thank for referring you to our office? _____

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT:

Patient/representative signature **X**_____DATE_____

Please allow us to photocopy your insurance card(s)

INSURANCE INFORMATION:

Payment for services rendered is to be made as follows:

"I request that payment of authorized insurance benefits be made to ADVANCED PHYSICIANS PC for any services or items furnished to me by the physician or supplier. I authorize the practice to release to the Health Care Financing Administration (HCFA/CMMS), my Insurance Carrier, and/or its agents appropriate information needed to determine these benefits or the benefits payable for related services, in accordance with HIPAA guidelines. Release of other information requires specific release authorization. I am financially responsible for appropriate deductibles, copayments, and non-covered items (which have been explained to me from information supplied by my carrier).

If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all costs of collection including the court costs and reasonable attorney fees."

X_____ _____

Signature of Beneficiary or Person Signing for Beneficiary Date Signed

_____ _____

Street Address, City, State, ZIP of Person Signing for Beneficiary Relationship

Reason beneficiary is unable to sign _____

DISSEMINATION OF MEDICAL INFORMATION:

To whom may we, as your health care providers, release information about your medical condition(s)?

NO ONE ☐

_____ _____

Relationship

_____ _____

Relationship

_____ _____

Relationship

X _____ _____

Signature of Patient or Responsible Party Date Signed

I, the undersigned, or as the parent or legal guardian of the undersigned authorize Dr. David Shusterman, MD and/or Dr. Molly McBride and/or Dr. Tamara Guichard, MD and/or Dr. Joel Hillelsohn, MD and/or Dr. Chongmin Kim, MD and/or Dr. Jeffery Tun, MD to render medical treatment to myself or the patient above for whom I am responsible.

X Signature:_____ Date:_____

Patient Intake Form (Check any that apply)

Reason for Your Visit-_____

Past Medical History- *None, Hypertension, Heart disease, Cholesterol, Diabetes gastric reflux, Other:*_____

Past Surgical History- *None. Appendectomy, Gallbladder, Prostate, Hysterectomy*

_____

Family History- *Non-contributory*._____

Medications- *None* _____

_____

Allergies- *None*_____

Social History-Alcohol intake- *NO Socially Daily.* **Smoking**- *No Yes Packs ___ Years___.*

Review of Systems: (Check any that apply)

General:	Generally healthy	*change in strength* *exercise tolerance* *weight change*
Head:	None	*headaches* *vertigo* *injury*
Breast:	None	*lumps* *tenderness* *swelling* *nipple discharge*
Chest:	None	*dyspnea* *wheezing* *hemoptysis* *cough*
Heart:	None	*chest pains* *palpitations* *syncope* *orthopnea*
Abdomen:	None	*change in appetite* *dysphagia* *abdominal pains* *bowel habit changes* *emesis* *melena*
Muscles:	None	*pain in muscles or joints* *limitation of range of motion* *paresthesias or numbness*
Neurologic:	None	*weakness* *tremor* *seizures* *ataxia* *changes in mentation*
Psychiatric:	None	*depressive symptoms* *changes in sleep habits* *changes in thought content*

XSignature:_____Date:_____

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits 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 a 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.

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 copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ **Provider Telephone Number:** _____

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)

NYS FORM OON-AOB (5/26/2015)