NEW WINDSOR
Family Medicine

Patient Demographic

Patient Information:

Last Name:_____ First Name:_____ MI:____

Sex (please circle) M F Social Security #:_____/_____/_____ Date of Birth: _____/_____/_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home#:_____ Cell#: _____ Work#: _____

Email_____ Marital Status (please circle): S M D W

Pharmacy:_____

Employer Name:_____ Occupation:_____

Employer Address:_____

_____ Employer Phone:_____

How did you hear about us?_____

Emergency Contact:_____ Phone:_____ Relation_____

Responsible Party Information (REQUIRED FOR MINORS)

Last Name:_____ First Name:_____ MI:___

Mother Maiden Name:_____

SSN:_____/_____/_____ Date of Birth:_____/_____/_____

Best Contact #_____ Email:_____

Street Address:_____ City:_____

State:_____ Zip:_____ Relation to Patient:_____

As a result of the federal government's American Recovery and Reinvestment Act (ARRA) of 2009, there are standards that are required for the use of Electronic Health Records (EHR), which we use in our office. One of the requirements is the collection of information on patients' race and ethnic background. As a result, we are asking patients to provide this information for inclusion in our records. You can decline to provide the information if desired by checking the decline to answer box. Thank you for your cooperation.

Race (Please Circle): American Indian/Alaska Native Asian Black/African American

Caucasion/White Hispanic Unknown Decline Other:_____

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Insurance Information

Primary Insurance Information:

Insurance Company:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip_____

Policy#_____ Group#_____ Copay $_____

Insurance Holder Info (if not yourself): Name_____

Address_____ City_____ State___ Zip_____

Date of Birth: ___/___/____ Sex: M___F___Employer:_____ Phone# Employer:_____

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Secondary Insurance Information:

Insurance Company:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip_____

Policy#_____ Group#_____ Copay $_____

Insurance Holder Info (if not yourself):

Name_____ Address_____ City_____

State_____ Zip_____ Date of Birth: ___/___/____ Sex: M___F___

Employer:_____ Phone# Employer:_____

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I authorize payment of Medicare or my present insurance carrier benefits be made directly to New Windsor Family Medicine, PLLC for services furnished to me by the provider. I authorize the release of any medical information about me to the holder to determine benefits payable for related services. I am aware that I am responsible for any unpaid balance regardless of insurance status, and also for any fees or charges incurred for returned checks, or should my account be turned over to a collection agency for non-payment of services. I acknowledge my responsibilities as a member of my insurance carrier and will comply with applicable copayments, coinsurances, and PCP requirements at the time of service.

_____ _____

Signature of Patient or Guardian Date

_____ _____

If Guardian, Please State Relationship to Patient Print Name

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Authorization for the Use and/or Disclosure of Protected Health Information

I authorize the use/or disclosure of my protected information only as directed below:
(please initial those areas authorized)

Type of information	Initial	Type of information	Initial
Appointment Information	____	Test results	____
Insurance information	____	Patient's presence in office	____
Clarify clinical information	____	**Any and all information**	____
Other_____	____		

I authorize my protected health information to be shared with me via e-mail (please initial):
E-mail Test Results ____
E-mail Address _____

I authorize the following entity to disclose my protected health information:
Name and address of office: **New Windsor Family Medicine, PLLC**
575 Hudson Valley Ave, Suite 201
New Windsor, NY 12553
I authorize the following person(s) to receive my protected health information:

Name:_____**Address (if different from patient):**_____

_____

Relationship to patient: _____

Telephone number(s): _____

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then this information would no longer be protected.
I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and I am aware that it is not effective to the extent that the person(s) I have authorized to use and/or disclose my protected health information have acted in re-liance upon it.

_____I authorize **one time release** of the information described above. This authorization expires when acted upon or **6 months from date of signature.**

OR

_____This authorization is for ongoing communication and remains in effect unless revokes in writing.

I do not have to sign this form in order to receive treatment from New Windsor Family Medicine I have read and understand the above and authorize disclosure of my protected health information as described.

Signature:_____ Date:_____

Name of Patient:_____ Patients Date of Birth_____

Name of Personal Representative:_____

Relationship to Patient:_____
*Parent,legal guardian, next of kin or legally appointed individual who represents the patient when the patient is:

1. Incompetent by judicial finding
2. Physically incapable
3. Mentally lacking capacity
4. A minor less than 18 years of age

UNLESS

Patient is pregnant. Patient is a parent
Patient has been legally married.

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IMPORTANT OFFICE POLICIES

MISSED APPOINTMENT POLICY

In order for us to be available as often and as soon as possible for all of our patients, especially in an emergency situation, we ask for 24 hours notice of cancellation of an appointment. There is a **$25 charge that is paid by you** (not chargeable to your insurance company) if you miss your appointment or cancel within TWO (2) HOURS of your scheduled appointment. That fee doubles with each missed appointment. There is a **$50 FEE for missing a Well Visit. These fees are due prior to making your next appointment.** Often times, we have patients on a waiting list that will fill late cancellations but we need some amount of time to be able to fill in those open spots. Additionally, if we find that you repeatedly miss appointments or regularly cancel within two hours of scheduled appointments, we will ask you to find a new Primary Care Provider.

PAYMENT POLICY

We expect that any payments due while you are here for your appointment be paid at that time, unless alternate payment arrangements have been made with the business office. All pre-determined co-payments are due at your appointment. If they are not paid, you are subject to a $5 service fee. If you should incur a bill that cannot be paid in full right away, we fully expect a regular monthly payment on your account. Payment arrangements may be made with the business office but are not necessary if you are paying on your balance monthly. If after three (3) months we do not receive payment, your bill is subject to be transferred to a collection agency. If this should occur, you will not be permitted to make another appointment or receive any services until the balance is paid in full.

Insurance Waiver: You should also understand that you are responsible for advising New Windsor Family Medicine of your current insurance. In the event that this does not happen and we are not contracted with your current company OR you have not chosen us (if appropriate to your policy) as your Primary Care Provider (PCP), you agree to pay your balance in full.

MEDICATION REFILLS

Please allow **AT LEAST** 24 hours for all medication refill requests to be processed. Depending on how much time has passed since your last visit, you may be asked to make an appointment in order to have your medication refilled.

I, _____ understand and agree to the terms of the above
(print name of responsible party)
policies. I will make every effort to abide by these policies and understand that not following the above policies may result in charges to my account and/or dismissal from New Windsor Family Medicine.

X _____
(Signature of responsible party)