

Midtown Medical Group

274 Madison Ave, Suite 304
New York, NY, 10016
Tel. 212. 696. 5900
Fax. 212. 696. 5909

NEW PATIENT REGISTRATION

Patient Information: (Please Print)

Name: _____ Date of Birth: ____/____/____
Address: _____ City, State, Zip: _____
Social security: ____ - ____ - ____ Marital Status: S / M / D / W Sex: Male/Female
Home Phone (____) ____ - ____ Mobile: (____) ____ - ____ Email: _____
Emergency Contact Name/Relation/Phone Number: _____ (____) ____ - ____
How did you hear about us: Google/Insurance Directory/Other _____

Employer information:

Employer Name: _____ Phone: (____) ____ - ____
Employer Address: _____ City, State, Zip: _____
Patient Occupation: _____

Insurance and Billing Information:

Name of Primary Insured: _____ Date Of Birth: ____/____/____
Insured Relationship to patient: Self / Spouse / Dependant
Primary Insurance Carrier: _____ Member ID: _____
Group No: _____ Need Specialist Referral: YES / NO
Insurance Company Address: _____ City, State, Zip: _____
Phone Number: (____) ____ - ____ Co-Pay Amount: _____

Secondary Insurance Carrier: _____ Insured ID: _____
Group No: _____ Need Specialist referral: YES / NO
Insurance Company Address: _____ City, State, Zip: _____
Phone Number: (____) ____ - ____ Co-Pay Amount: _____

Insurance Authorization and Assignment of Benefits:

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: ____/____/____ Signature: _____

I hereby authorize **Midtown Medical Group**, to apply for benefits on my behalf and I request that all payments be made from my insurance company directly to the physicians. I permit a copy of this authorization to be used in the place of the original. I understand that I am responsible for any amount not covered by my insurance unless my doctor is not a participant of my insurance plan. I have reported with regard that my insurance coverage is correct.

Date: ____/____/____ Signature: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I hereby received, read and understand your Notice Of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time the address above to obtain a current copy of the Notices of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand, you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Further, I give permission to the doctors and/or their authorized representatives at Midtown Medical Group, to communicate test results and other private medical information to me via the following (please indicate acceptance or rejection for each of the following):

Yes () No () Secure voicemail/answering machine (____)____ - _____

Yes () No () Secure fax number (____)____ - _____

Yes () No () Secure Email _____

Yes () No () Other _____

Print Name: _____

Relationship To Patient: _____

Signature: _____

Date: ____/____/____