Farmingdale Primary Care

202 Fallwood Parkway
Farmingdale, NY 11735

PATIENT REGISTRATION
PLEASE FILL OUT ALL QUESTIONS

Name:	Today's Date:
DOB:	Soc. Sec:
Address: _____ _____ _____	Home #: Work #: Cell #: Email:
ER Contact:	Relationship:
ER Contact #:	
Employer/Occupation:	

SMOKING STATUS

☐ NO
☐ YES If yes, how many packs per day?_____ For how many years?_____
☐ FORMER If former, what year did you quit? _____

INSURANCE INFORMATION

Primary Insurance Name:	ID:
Name of Insured:	Relationship:
DOB:	Soc. Sec:
Secondary Insurance Name:	ID:

NON-MEDICARE PATIENTS: I request that payment of authorized benefits be made either to me or on my behalf to the practice for services rendered by my physician. I authorize any holder information about me to release to my insurance company and/or it's agents, any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the practice for services rendered by my physician. I authorize any holder of medical information about me to release to the Health Care Financial Administration and/or it's agents, any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

MAY WE LEAVE MESSAGES ON:

Home	Yes	No
Cell	Yes	No
Work	Yes	No

Medical Information may be released in case of emergency to the following person(s):

Name/Relationship:_____ Phone# _____
Name/Relationship:_____ Phone# _____
Name/Relationship:_____ Phone# _____

Authorization form

Farmingdale Primary Care P.C.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Farmingdale Primary Care P.C.**

to use and/or disclose certain protected health information (PHI) about me to

_____.

This authorization permits **Farmingdale Primary Care P.C.** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **[enter date or defined event]**.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Farmingdale Primary Care P.C.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Farmingdale Primary Care P.C.
202 Fallwood PKWY
Farmingdale NY, 11735

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name _____ Date _____

Print Name of Patient or Legal Guardian, if applicable _____

Patient/guardian must be provided with a signed copy of this authorization form.

Note: *This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (e.g., your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

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FARMINGDALE PRIMARY CARE
202 Fallwood Pkwy
Farmingdale, NY 11735

Cancellation Policy/ No Show Policy for Routine Visits and Surgery

1. *Cancellation/ No Show Policy for Doctor Appointments*
   a. We under stand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment schedule.
      i. **If an appointment is not canceled at least 24 hours in advance, you will be charged twenty-five dollar ($25) fee; this will not be covered by your insurance company.**
         1. ***Subsequent missed appointment may result in the discharge from the practice.***

2. *Scheduled Appointments*
   a. We understand that delays can happen, however we must try to keep other patients and the doctor on time.
      i. **If a patient is 15 minute past their appointment time without proper notification, we will have to reschedule the appointment for another date and time.**

3. Bounce Check Fee
   a. As per your insurance carrier, payment is due upon receipt. Payment can be made in the form of cash, credit, money order and check.
      i. **If a check is is unable to be process due to insufficient funds, there will be a surcharge of twenty-five dollar ($25) for bounce check fee plus the amount due.**

4. Account balances
   a. We will require that patients with self-pay balance do pay their account balance to zero (0) prior to receiving further services by out practice. Patients who have questions about there bills or who would like to discuss a payment plan option may call and asked to speak to the business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Print name _____ Signature _____ date _____