ATLANTIC GASTROENTEROLOGY

PATIENT INFORMATION (*ЛИЧНАЯ ИНФОРМАЦИЯ)*

Today's Date: _____

Last Name:_____ **First Name:**_____ **Sex: M__ F__**

Social Security # ☐☐☐-☐☐-☐☐☐☐ **Birth Date:** ☐☐-☐☐-☐☐☐☐

Home Address _____

Apt#_____ **City** _____ **State**_____ **Zip**_____

Home Phone: *(Телефонный номер)* _____

Cell Phone: _____ **Work Phone:** _____

Emergency Contact _____ **Phone #**_____

Primary Doctor *(Имя лечащего врача)* _____

Your PHARMACY phone number (Телефон Вашей аптеки) _____

How did you hear about this clinic, or who referred you here? (*Как вы о нас узнали/кто направил вас к нам?)*

_____

Do we have your permission to leave message on your answering machine at home? **Y** _____ **N** _____
***Разрешение оставить сообщение? Да*☐ *Нет*☐

May we discuss your condition with any member of your household? **Y**__ **N**__ Whom? _____
***Разрешение огласить ваш диагноз кому-либо? Да*☐ *Нет*☐

Your E-MAIL Address is*:* _____@_____

Insurance Information:

Primary Insurance Carrier:_____

Name of Insured (Guarantor): _____ Guarantor Date of Birth:_____/_____/_____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth:_____/_____/_____

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as a guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to the provider or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, the provider originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality.

I understand that the provider maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is available in the waiting room area per patient's request. I understand that the provider reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review th4e notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of the provider at 2797 Ocean Parkway, Brooklyn, NY 11235.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above