New York House Call Physicians®

DBA DOCTOR IN THE FAMILY

Revised April 25th, 2017

DOCTOR IN THE FAMILY NEW PATIENT FORM

DOCTOR IN THE FAMILY is a group medical practice fully licensed by the New York State Department of Education. Our goal is to provide the highest standards of primary and urgent medical care with minimal paperwork, waiting, complex fees, and policies.

NOTICE OF PRIVACY PRACTICE & SECURITY:

In accordance with the Health Insurance Portability Accountability Act of 1996 (HIPAA), DOCTOR IN THE FAMILY will keep all of your health information confidential. This means that your medical records, demographics, and anything related to your health will not be released or discussed without your written consent or explicit permission. Our website and electronic medical records are SSL encrypted with 128/256 bit security.

NOTE FOR MEDICARE AND MEDICAID PATIENTS: DOCTOR IN THE FAMILY does not participate with Medicare or Medicaid. Medical services covered by Medicare and Medicaid may not be billed to Medicare or Medicaid. You will not be reimbursed for services mediated by DOCTOR IN THE FAMILY.

NOTE REGARDING FEES: Some health insurance companies have "copays" or "coinsurance." These fees are due at the time of service. DOCTOR IN THE FAMILY does not have any contractual agreements with any health insurance companies. We may participate with your insurance company "out of network." This means that you are responsible for paying our fees at the time of the consult or in the event your insurance company does not reimburse us for medical services provided.

IF YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE DO SO 1 BUSINESS DAY IN ADVANCE OR A CANCELLATION FEE MAY BE CHARGED.

MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THE ABOVE:

Patient or Guardian Signature_____

Today's Date: _____

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Patient Name & Address:_____

Patient Phone Number: _____

Patient Date of Birth_____

Patient Email [we do NOT send spam or disclose your email]:_____

Patient Social Security Number: _____

Patient Health Insurance Plan Name and Member ID Number: _____

Patient Health Insurance Phone Number: _____

BILLING INFORMATION:

Name on Credit Card:_____

Credit/Debit Card Number:_____

Card Expiration Date:_____

Card Verification Number:_____

PHARMACY INFORMATION:

Pharmacy Name, Address, Phone #:_____

Witness Name and Signature _____

Today's Date & Time: _____

MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THE ABOVE:

Patient or Guardian Signature_____

Today's Date: _____