North Shore-Long Island Jewish Health System

Faculty Practice Plan
REGISTRATION FORM
Please Print Legibly

I. Patient Information:

Patient Name ______________________ (Last) ______________________ (First) Sex ___ M ___ F Date of Birth ______ / ______ / ______

Social Security # ______ - ______ - ______ Marital Status ______ (S M W D) Home Telephone # ______________________

Preferred Language ______________________ Email Address ______________________ Cellular Phone # ______________________

Address ______________________ (Street) ______________ (City) ______ (State) ______ (Zip)

Father's First Name ______________________ Mother's First Name ______________________ Are you employed? ___ Yes ___ No

Emergency Contact ______________________ Telephone Number ______________________ Relationship ______________________

II. Referring Physician:

Physician Name ______________________ (Last) ______________________ (First) Telephone Number ______________________

Address ______________________ (Street) ______________ (City) ______ (State) ______ (Zip)

Primary Care Physician (If Different from Above) ______________ (Name) ______________ (Address) ______ (City) ______ (State) ______ (Zip)

III. Employer Information:

Name of Employer ______________________ Work Number ______________________ ext ______

Address ______________________ (Street) ______________ (City) ______ (State) ______ (Zip)

IV. Spouse Information:

Spouse's Name ______________________ (Last) ______________________ (First) Sex ___ M ___ F Date of Birth ______ / ______ / ______

Spouse's Social Security # ______ - ______ - ______ Spouse Employed by ______________________

Spouse's Employer Address ______________________ (Street) ______________ (City) ______ (State) ______ (Zip)

Insurance Information: *(Please provide insurance cards for verification)*

V. PRIMARY Insurance Coverage ______________________ (Name of Insurance Carrier) Relationship to Subscriber ______________ (Self, Spouse, Child, Student)

Subscriber's Name ______________________ (Last) ______________________ (First) Subscriber's Date of Birth ______ / ______ / ______

Subscriber's Social Security Number ______________________

Insurance ID Number ______________________ (Please provide number from Card) Group Number ______________________ Plan Number ______________________

Claims Address ______________________ (Street or PO Box) ______________ (City) ______ (State) ______ (Zip)

VI. SECONDARY Insurance Coverage ______________________ (Name of Insurance Carrier) Relationship to Subscriber ______________ (Self, Spouse, Child, Student)

Subscriber's Name ______________________ (Last) ______________________ (First) Subscriber's Date of Birth ______ / ______ / ______

Subscriber's Social Security Number ______________________

Insurance ID Number ______________________ (Please provide number from Card) Group Number ______________________ Plan Number ______________________

Claims Address ______________________ (Street or PO Box) ______________ (City) ______ (State) ______ (Zip)

Authorization for release of information by Faculty Practice Plan at NSLIJ Health System

I hereby authorize and direct the above named faculty practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

VII. ______________________ (Signature of Patient or Authorized Representative) ______ / ______ / ______ (Date)

I hereby assign, transfer, and set over to the above named faculty practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carries, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

VIII. ______________ ______ / ______ / ______

Financial Policy

The following is our financial policy. We are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

INSURANCE CARDS: We will request to photocopy your insurance cards(s) for your file. If you have more than one insurance plan, please be sure to present all your cards.

CO-PAYMENT PLANS: The Health Insurance Portability & Accountability Act requires that we collect your carrier co-payments at the time of service. Please be prepared to pay them at this time. If we participate in your plan, we will accept the designated fee.

NON CO-PAYMENTS: If your insurance plan does not require a co-payment, and we participate in your plan, we will also accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

NON-PARTICIPATING PLANS: The doctors at our Center wish to work with you in every way possible. If you have a plan in which we do not participate in, arrangements can be made to accept your insurance companies' fees to non-participating doctors. You are responsible for any yearly deductibles that have not been met. Please speak with our accounts representative in regard to these plans.

REFERRALS: If your plan requires a referral from a primary care physician, it is **YOUR** responsibility to obtain it and have it with you at the time of your office visit. We will also accept referrals that are faxed to us from your physician's office if they are received prior to your visit. Your insurance company will not make payment of your bills without the proper referrals.

This office will obtain the proper precertification for your surgery if surgery is necessary, however, many insurance plans stipulate that they be informed of pending surgery by the patients also. Not doing so could jeopardize your payment. Therefore, it is **YOUR** responsibility to call your insurance company and make them aware of your upcoming surgery.

MEDICARE: We will submit claims to Medicare for the Medicare allowed amount. You are responsible for your deductible and the 20% co-insurance. If you have a secondary insurance, we will bill them for you also.

Anesthesia and **Hospital** costs are billed **separately** and have nothing to do with our fees to you. Please speak with your insurance company if you have any questions in regard to these fees.

You are responsible for the timely payment of your account.

Thank you for taking the time to review our policy. Please feel free to ask any questions or share your special concerns with us.

Patient Signature______________________________ Date______________________

Responsible party signature if not the patient__________________________ Date______

I agree to allow disclosure of my PHI (including date/time of appointments) to:

___ My Spouse ____
(Printed name and phone number)

___ Member(s) of my Family ____

____

____
(Printed name and phone number)

___ Other ____
(Printed name and phone number)

___ Myself only

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the *Notice of Privacy Practices*.

____
Print Name of Patient or Legal Representative Date

____
Signature of Patient or Legal Representative Date

____
Relationship to patient

Authorization to release information via e-mail

By proving your e-mail address, you agree to receive e-mail information about your healthcare, including protected health information.

______________________________ ______________________
Signature Date

This does not serve as an Authorization to Release Medical Records

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ an emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Witness: ______________________________ Date: ______________________

ADDRESSOGRAPH

NORTH SHORE-LIJ HEALTH SYSTEM

ACKNOWLEDGEMENT OF RECEIPT

I have received a copy of the Provider's Notice of Privacy Practices.

Patient/Agent/Relative/Guardian* (Signature) Date / Time

Print Name Relationship if other than patient

Telephonic Interpreter's ID #

OR

Signature: Interpreter

Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time

Print Name

PROVIDER USE ONLY

_______ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_______ Patient unable to sign

Signature Date Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

SYSHIPAA (8/23/13)