MODERN MEDICAL CARE P.C.

2076 HYLAN BLVD
STATEN ISLAND, NY 10306
TL: 718-979-4865 FX: 718-979-1842

PATIENT REGISTRATION FORM

LAST NAME _____ FIST NAME_____MI___

DOB _____SS #_____

HOME ADDRESS _____

CITY _____STATE _____ ZIP_____

HOME PHONE _____CELL PHONE _____

EMERGENCY CONTACT NAME_____

EMERGENCY PHONE NUMBER _____ RELATION _____

PHARMACY PRONE NUMBER _____

MEDICAL INSURANCE INFO

NAME OF INSURANCE _____MEMBER ID NUMBER_____

NAME OF SUBSCRIBER _____

RELATION TO PATIENT _____SELF_____ PARENT _____PARTNER _____OTHER

MEDICAL HISTORY

ALLERGY _____

SURGERY_____

MEDICATION _____

_____

PAST MEDICAL HISTORY _____

_____

AGREEMENT OF FINANCIAL RESPONSIBILITY

Tank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. the following is a statement of our financial policy, which we require that you read and agree to provide to any treatment.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are provided, we accept cash credit cards, and pre-approved insurance for which we are a contracted provider.

It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage, should you fail to provide this information, you will be financially responsible.

If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time claim is received by the insurance company. If we do not contract with your insurance company you will be expected to pay for all services rendered at the end of your visit we will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of payment and ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Please understand some insurance coverage's have Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services are part of an Out-of-Network benefits, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Name of Patient/responsible Party (please print) Relation to Patient

_____

Signature of Patient/Responsible Party _____

Date_____

INFORMED CONSENT FOR TELEHEALTH SERVICES DURING A PUBLIC HEALTH EMERGENCY

By virtue of my participation in this telehealth visit. I am consenting to receive though telehealth. Telehealth is the use of electronic information and communication technologies by providers to deliver care to patients at a distance.

I understand that any care provided to me though telehealth will incorporate security protocol to protect the privacy of my health information. I understand that the technology may not contain appropriate security protocols to protect the privacy and security of my health information. My provider has explained to me the risks associated with the technology that he or she is using to provide care to me. I acknowledge that there are potential risks associated with any the technology used while obtaining care through telehealth, including but not limited to, connectively interruptions, other technical difficulties, and unauthorized access by third party to one's health information. Despite these risks, I agree to participate in the telehealth encounter.

I understand and agree that I or healthcare provider may terminate a telehealth encounter at any time in the event of a technical malfunction.

I also understand that my location determines where medicine is being practiced. As a result, I will inform my provider where I am located at the time of my telehealth visit.

I understand that there may be costs associated with telehealth visit. I agree that I am responsible for any fees associated with the telehealth services that I receive.

This information Consent for Telehealth Services During Public Health Emergency will remain in effect solely during the term of the public health emergency.

By signing below, I certify that:

I have read or had this form read and/ or had this form explained to me;

I fully understand the contents of this document, including the risks and benefits of receiving telehealth services;

I have been given ample opportunity to discuss any questions I may have regarding the telehealth services and that all my questions have been answered to mu satisfaction.

Patient/Guardian Signature:_____

Print Name of person signing this form:_____

Date _____