



BORO PARK OBSTETRICS AND GYNECOLOGY, P. C.

DR. IGAL REIZIS, DR. JACK TROPER, DR. MOSHE SCHWARTZ,
DR. ARIE SCHWARTZ, DR. MATTHEW SILVERMAN,
DR. GREGORY KLIOT, DR. ELAINE SKLAR, DR. KATARZYNA PERLMAN,
DR. SHIRA ALTER, DR. YVONNE NOEL

New Patient Registration

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____ City: _____ Zipcode: _____

Social Security: _____ Email: _____

Last menstrual period: _____ Allergies: _____

Telephone (work/home): _____ Cell Phone: _____

Emergency Contact: _____ Telephone: _____

Do you have insurance coverage? Yes No

Name of Insurance Company: _____

Name of Insured: _____ Relationship to you: _____

Date of Birth of Insured: _____ SSN of Insured: _____

ID: _____ Group #: _____

Do you have secondary insurance? Yes No

Preferred Pharmacy Name and Address: _____

Pharmacy Telephone: _____ Pharmacy Fax: _____

How did you hear about us? _____

5925 15th Avenue, Brooklyn, New York 11219 Tel 718-972-2700 Fax 718-972-2701
52D Broadway, Brooklyn, New York 11211 Tel 718-388-2700 Fax 718-388-0104
1414 Newkirk Ave., Suite A., Brooklyn NY 11226 Tel 718-693-1011 Fax 718-282-7298

Please be advised...

TESTS: SONOGRAMS, NON-STRESS TESTS, AND FETAL BIOPHYSICAL PROFILES ARE PERFORMED IN OUR OFFICE. THESE TESTS ARE NORMALLY COVERED BY INSURANCE; BUT THERE IS NO GUARANTEE OF PAYMENT.

LABORATORY TESTING: WE PROVIDE OUR PATIENTS WITH A LABORATORY TECHNICIAN ON OUR PREMISES. YOUR LAB WORK AND YOUR CURRENT INSURANCE INFORMATION, IF ANY, WILL BE SENT TO EITHER OUR LAB OR TO THE DESIGNATED LAB BY YOUR INSURANCE COMPANY. YOU WILL RECEIVE A SEPARATE BILL FOR THE LABORATORY SERVICES FOR WHICH YOU OR YOUR INSURANCE WILL BE RESPONSIBLE.

PREGNANT: YOU HAVE A CHOICE TO SEE ALL OB PROVIDERS DURING YOUR PREGNANCY OR ANY ONE PRIMARY DOCTOR FOR CONTINUITY OF CARE. ONLY THE PROVIDER SCHEDULED TO BE ON CALL FOR THE HOSPITAL WILL ATTEND YOUR DELIVERY.

PAYMENT: WE DO NOT ACCEPT ASSIGNMENT OF INSURANCE UNLESS WE PARTICIPATE AS A PROVIDER IN YOUR INSURANCE COMPANY. THEREFORE, IF YOU DO NOT HAVE INSURANCE OR WE ARE NOT IN YOUR INSURANCE COMPANIES NETWORK, THEN PAYMENT IS DUE AT THE TIME OF YOUR VISIT AND A RECEIPT WILL BE PROVIDED FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT. IF WE ACCEPT YOUR INSURANCE, YOUR INSURANCE INFORMATION MUST BE PRESENTED AT TIME OF VISIT OR YOU WILL BE HELD LIABLE FOR ANY UNTIMELY FILING. **PLEASE PAY YOUR CO-PAYMENT AT THE TIME OF YOUR VISIT. THERE WILL BE A \$25 CHARGE FOR ANY RETURNED CHECK. THANK YOU FOR YOUR COOPERATION.**

YOU WILL BE RESPONSIBLE FOR THE BALANCE IF YOUR INSURANCE DENIES PAYMENT.

My signature below indicates that I agree to release any information requested for insurance purposes and to assign any and all insurance benefits to the above providers. I also agree that in the event my insurance allows balance billing, denies payment for noneligibility or does not cover a procedure or test, I will be responsible for any remaining balance.

SIGNATURE OF PATIENT _____ DATE _____

Acknowledgement of Receipt of Privacy Notice

The purpose of this form is to confirm acknowledgement of receipt of Privacy Notice as required by the Health Information and Portability and Accountability Act of 1996 (HIPAA). Should such acknowledgement be unobtainable, this form will document will confirm Boro Park's good faith attempt to obtain such acknowledgement.

I acknowledge receipt of the Boro Park Obstetrics and Gynecology, P.C., Privacy Notice and Practices. I have read and understood these practices and my Protected Health Information privacy rights as stated in the Company notice materials.

Signed: _____ Date: _____

Print Name: _____

In the event that the patient's signature was not obtained because the patient did not return the form, the undersigned employee of Boro Park Obstetrics and Gynecology, P.C., acknowledges that the patient received the referenced Notice of Privacy Practices at the time of check-in for his or her first visit.

Signed: _____ Date: _____

Employee's Name: _____

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Patient Disclosure Authorization Form

Patients Name: _____

Date: _____

Date of Birth: _____

I hereby give authorization to disclose my Protected Health Information (PHI) only in the specific manner and to the specific individual(s) directed below.

Recipient of Information:

Name: _____ Relationship to Patient: _____

(Circle below to designate how you wish your information to be disclosed and if you would like any restrictions).

Manner(s) of communication allowed regarding my PHI:

Telephone

Fax

Mail

Restrictions to Disclosure:

Access all medical records

Last visit only

Test results only

Other

I understand this authorization provides that:

- I have the right to access any protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing at the address listed below.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use.
- I will receive a copy of this completed and signed authorization form.

Signature: _____

Date: _____