INSURANCE INFORMATION

(PLEASE PRINT)

Last Name_____ First Name_____ M.I.____ DOB _____

SocialSecurity#_____Race/Ethnicity_____Preferred Language_____

Street Address _____ APT # _____ City _____ State _____ Zip _____

Home #_____ Work # _____ Cell # _____

Employer Name _____ Employer Address_____

City _____ State _____ Zip _____ Chief Complaint _____

Emergency Contact Name: _____ Tel #_____

****IF PATIENT IS UNDER THE AGE OF 18, WE REQUIRE RESPONSIBLE DOB AND SOCIAL SECURITY NUMBER****

Name _____ DOB _____ Social Security # _____

****PRIMARY CARE PHYSICIAN** _____ PHONE NUMBER _____

Who referred you to us? [ ] Doctor [ ] Relative/Friend [ ] Ad [ ] Passed by Office [ ] Lawyer [ ] Ins. Book

If you checked *Doctor* or *Lawyer* please provide name and number: _____

PRIMARY INSURANCE: _____ Insurance Co. _____

Insurance ID# _____Group # _____ Street Address_____

SECONDARY INSURANCE _____ Insurance Co. _____

Insurance ID# _____ Group #_____ Name_____ SS# _____

WORKERS COMP: Were you injured on the job?___ Date of injury_____ Body Part(s)_____

Adjuster Name _____ Adjuster Phone _____Fax_____

Comp. Carrier_____ Address_____ City/State/Zip_____

NO FAULT: Were you injured in an accident? _____ Date_____ Ins. Carrier_____

Address_____City/State/Zip_____ Body Part(s)_____

***All professional services are charges to the patient. The patient is responsible for all fees regardless of insurance coverage. I understand that I am responsible for my bill. I hereby assign all medical and surgical benefits to include major medical benefits including Medicare, Private Insurance, and other plans to Dr. Albert Graziosa M.D.,P.C. I give authorization to give any information to my insurance company that they may need.**

PATIENT SIGNATURE (If over 18) _____ DATE_____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

Albert Graziosa, M.D, P.C.
3611A East Tremont Ave.
Bronx, NY 10465

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

ALBERT GRAZIOSA, M.D., P.C
Orthopedic Surgeon
Sports Medicine

NOTICE OF PRIVACY PRACTICES AND PATIENT ACKNOWLEDGEMENT

To Our Valued Patient

The misuse of personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI.As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome you input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in <u>your</u> best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to you treatment, payment or healthcare operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPPA privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name:_____

Signature:_____ Date:_____

If minor, signature of parent or guardian:_____

Thank you for being one of our highly valued patients

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<u>For Office Use</u>

A "good faith Effort" was made to get a signature from patient. Signature was not attained due to the following:_____

_____

ALBERT GRAZIOSA, M.D., P.C.
3611 A EAST TREMONT AVENUE
BRONX, NY 10465

NOTICE TO ALL COMMERCIAL INSURANCE PATIENTS

If you are covered by **GHI, BC/BS** or some **United Healthcare** policies, please be advised that we are an **Out-of-Network** provider. If you have **Out-of Network** benefits you can be seen by an Out-of-Network provider, however in most cases the payments made by the insurance company will be sent directly to you, the subscriber, We will accept that payment along with your deductible or/and coinsurance (if there is any)as payment in full, there will be no extra charge to you, as the patient.

- You will only be charged your **co-payment** the time of your visit.
- If you have a **deductible or/and coinsurance** this amount is determined by your insurance company. Your insurance company will inform us of the deductible or/and coinsurance amount, when our billing office receives an **Explanation of Benefits**(EOB) at that time our billing office will bill you for that amount.

As stated above, the Out-of-Network insurance coverage will be paid directly to you by your insurance company. You must mail or drop off the check to Dr. Graziosa office with the explanation of benefits. The check must be signed on the back of the check by the subscriber.

If you do not forward the endorsed insurance check or a personal check for that amount, you will then be responsible for the charges that were submitted to the insurance company.

All payments are due 7-10 days after you receive your bill from our billing office .

By signing below, you agree with this policy of returning the check to our office or paying all billed amounts in full.

Thank you for your cooperation.

PATIENT SIGNATURE_____ DATE_____

Revised 12/19/2011