

CASE#:

55 E 86TH ST, #1A New York, New York 10028 (212) 348-3636

PATIENT INFORMATION

PATIENT NAME:		
DATE OF BIRTH:		
ADDRESS:		
CITY:STATE:ZIP:		
PATIENT SOCIAL SECURITY #:		
HOME PHONE:		
WORK PHONE:		
MOBILE PHONE:		
EMAIL:		
REFERRING PHYSICIAN:		
REF. PHYSICIAN PHONE:		
REF. PHYSICIAN FAX:		
PRIMARY PHYSICIAN:		
OCCUPATION:		
EMPLOYER'S NAME:		
PHARMACY:		
THANNACT		
EMERGENCY CONTACT:		
EMERGENCY CONTACT:		
NAME:		
NAME:CONTACT #:		
NAME:		
NAME:CONTACT #:RELATIONSHIP:		
NAME:		
NAME:_ CONTACT #:_ RELATIONSHIP:_ INSURANCE INFORMATION PRIMARY INSURANCE:_ MEMBER ID#_ GUARANTOR:_ GUARANTOR DOB/SS#:_ SECONDARY INSURANCE:_ MEMBER ID:_ WORKER'S COMPENSATION OR NO FAULT DATE OF ACCIDENT:_ INSURANCE CO. NAME:_ INSURANCE PHONE:_		
NAME:		

MY APPOINTMENT TODAY IS WITH (PLEASE CHECK):

- DONALD ROSE, MD
- o THOMAS YOUM, MD
- o CRAIG CAPECI, MD
- o Martin Quirno, MD

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all physicians of RYC Orthopaedics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize RYC Orthopaedics to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.		
SIGNATURE:	DATE:	
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES		
I, the undersigned, have been informed sign this <i>Notice of Privacy Practices</i> . The <i>HIPPA Act of 1996</i> to protect patient text of the Act is available to me upon respectively.	ne privacy regulations were created by t privacy. I understand that the full	
SIGNATURE:	DATE:	
CANCELLATION POLICY		
I, the undersigned, understand that as a cancel my appointment at least 24 hou to do so will result in a \$50 cancellation.	rs prior to my appointment. Failure	

WORKERS' COMPENSATION ONLY

SIGNATURE: _____ DATE: ____

You may become responsible for the medical costs of treatment for you illness or condition with the provider listed above if (1) you fail to prosecute the claim for workers' compensation or (2) It is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment. NY-WCB A9 (1-07)

SIGNATURE:	 DATE:

MEDICARE PATIENTS ONLY

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to RYC Orthopaedics for services furnished to me by RYC Orthopaedics. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.