New York Obstetrics & Gynecology, P.C.
Alan Adler, M.D., FACOG
Howard Kurtz, M.D., FACOG
Rachel Kassenoff, M.D., FACOG
Julianne Biroschak, M.D.
Alicia Carranza, M.D.
Michelle Wallenstein, M.D., FACOG

Referred by:_____ **Today's date** _____/_____/_____

Patient's Name: Last_____ **First**_____ **MI**_____

Patient's Address_____**City**_____**ST**_____**Zip**_____

Cell ( )_____ **Home** ( )_____ **Work** ( )_____

Email _____
(Only for Appointment Confirmation, NOT for communication with physicians or staff)

D.O.B_____/_____/_____ **Social Security #**_____-_____-_____ **Marital Status:** Single Married Divorced Widowed

In a life or death situation, would you accept a Blood Transfusion (MANDATORY) YES or NO

Employer_____

Responsible Party_____ **Relationship**_____
(If other than patient) Last First

Address_____**City**_____ **ST**_____ **Zip**_____

Emergency Contact/Relationship_____ **Phone** ( ) _____ Cell Home Work

Primary Insurance

Insurance Name_____ **Insurance Phone** ( )_____

Subscriber's Name_____ **D.O.B**_____/_____/_____ **Relationship**_____

Member's #_____**Group #**_____**Group Name**_____ **Employer** _____

Secondary Insurance

Insurance Name_____ **Insurance Phone** ( )_____

Subscriber's Name_____ **D.O.B**_____ **Relationship**_____

Member's #_____**Group #**_____**Group Name**_____ **Employer** _____

Assignment of Benefit and Waiver of Liability

I hereby authorize the release of medical information relating to all claims for benefits submitted on my behalf and/or my dependents. I further authorize payments for all billed services to be made directly to NY ObGyn, P.C. I understand and agree to be financially responsible for any balances not covered by my insurance plan.

Signature of Subscriber or Spouse_____ Date_____/_____/_____

I understand, have agreed to provide New York Obstetrics & Gynecology, P.C. with the necessary referrals and documents to bill my insurance plan. If I elect to be seen without a referral, I agree to accept financial responsibility for all charges incurred. If the referral I provide is not valid for the services received I will be responsible for all balances due to NY ObGyn, P.C. I accept this responsibility on my behalf and/or my dependents.

Signature of Subscriber or Spouse_____ Date_____/_____/_____

NYOBGYN of Mount Sinai

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234 East 85th Street, New York, NY 10028 • Tel (212) 535-9607
465 Ocean Parkway, Brooklyn, NY 11218 • Tel (718) 826-6179
101 Broadway, Suite BO2, Williamsburg, NY 11249
300 Cadman Plaza West, 17th fl, Brooklyn Heights, NY 11201
www.nyobgynpc.com

Introduction to Privacy Notice

Dear Patient,

This is a summary of the ways in which medical information about you may be used and disclosed, and how you can get access to this information. New York Obstetrics & Gynecology, P.C. will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. For example, your medical information may be used by the health care professional treating you, by the office insurance coordinator to process your payment for the services rendered, and by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable Federal and State law.

The complete Notice of Privacy Practices is attached. We encourage you to read the entire Notice. You are required to acknowledge in writing that you have received a copy of the Notice.

The attached Notice is effective as of April 14, 2003.

Sincerely,
Drs. Adler, Kurtz, Kassenoff, Biroschak, Carranza & Wallenstein

……

Patient Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information

I hereby acknowledge that I have received a Notice of the Privacy Practices for Protected Health Information from New York Obstetrics & Gynecology, P.C.

Signature (Patient or Representative): _____

Print Name (Patient or Representative): _____

Date: _____

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Dear Patient:

Please be advised that effective August 1, 2006 our office has implemented new billing procedures. We require that each patient provide a current credit card imprint when arriving for each visit. By providing your credit card imprint and signing below, you are authorizing us to charge your credit card for any unpaid balances relating to care we have provided you. We will mail you a copy of the charge receipt. **For any amounts owed greater than $600, we will not notify you at the time we charge your credit card.**

Sincerely,
Drs. Adler, Kurtz, Kassenoff, Biroschak, Carranza & Wallenstein

Print Name: _____

Agreed to and Accepted by: _____

Date: _____

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NYOBGYN of Mount Sinai are **in-service providers** for the following insurance carriers:

AETNA: PPO and HMO

CIGNA: Cigna, Great West and Nippon

Empire Blue Cross Blue Shield: HMO, POS, PPO (NO Empire –Health Plus)

GHI/Emblem

HIP/Emblem

HIP Healthcare Partners

HIP Montefiore

Horizon Blue Cross Blue Shield: Most PPO and HMO Plans

Magnacare: Magnacare, Oscar, Health Republic

Medicare: Medicare, Oxford Medicare, United Healthcare Medicare

Multiplan/PHCS

Oxford Health Plans

POMCO

United Healthcare: Commercial (NO Community or Compass Plans)

Exchange Plans:

Empire BCBS Commercial (including Pathway and Blue Priority)

Empire BCBS Pathway Enhanced

NYOBGYN of Mount Sinai are **out-of-network providers** for the following insurance plans: Blue Cross Blue Shield Senior Plan, 1199, Fidelis, GHI HMO, HIP Medicaid Plan, Americhoice, Healthfirst, and all Medicaid Plans.

Agreed to and Accepted by (signature): _____

Print Name: _____ Date: _____

NY OBGYN of Mount Sinai

SECURE MESSAGING SERVICE ENROLLMENT

We are happy to announce **Doctor Direct**, our new private and secure communication system that allows you to correspond with our office via a protected website.

Sign up for **Doctor Direct** and you will have the ability to receive your results as well as contact our appointment staff and surgical coordinators through our secure website.

For any non-urgent questions regarding your appointments, surgical scheduling, or prescription refills, you will be able to sign into our system and communicate with our staff. **For all urgent matters, please continue to call the office directly.**

We encourage you to participate in this program to enhance our service to you. After completing the form below, you will receive a confirmation email with additional instructions to complete enrollment. If you do not receive an email from us in the next few days please check your spam folder and adjust your spam filter accordingly if necessary.

PLEASE NOTE: Lab results and other personal medical information will NOT be sent to your email address. Information will only be accessible to you through our secure website, using your private log-in name and password.

YOU MUST RESPOND TO THE EMAIL YOU RECEIVE FROM SUPPORT.NYOB@MEDRECORDSALERT.COM IN ORDER TO ACTIVATE THIS SERVICE!
PLEASE WRITE AS NEATLY AS POSSIBLE!

Name: _____

Date of Birth: _____

Email Address: _____

Signature: _____

Pharmacy Name: _____

Pharmacy Phone No. and Zip Code: _____

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Thank you!
-Drs. Adler, Kurtz, Kassenoff, Biroschak, Carranza & Wallenstein