CareMed
Primary & Urgent Care

266 Middle Country Road, Coram, NY 11727 P: 631-698-1111
1 E Roe Blvd, Patchogue, NY 11772 P: 631-475-3900
900 Straight Path, W Babylon, NY 11704 P: 631-957-0066

PATIENT INFORMATION

Reason for today's visit: _____ **Last Visit Month/Year**_____
Car Accident? _____**Yes** _____**No** **on the Job Injury?** _____**Yes** _____**No**
Date: _____ How did you hear about us: _____

Patient Name: (**PRINT**)_____Date of Birth: _____

SS#:_____ Sex: ___Male ___Female Marital Status: ___M ___S ___Other

Address: _____City:_____State_____ Zip_____

Phone#: Home_____Cell_____Work_____

Email Address: _____

Primary Care Physician: Name_____Phone#_____

Name/Address Employer: _____

PRIMARY CARE INSURANCE

Insurance Name_____ ID/Policy#_____ Group: _____

Address: _____City: _____State_____Zip_____

Policy Holder Name: _____Relation: _____DOB_____

SECONDARY INSURANCE

Insurance Name_____ ID/Policy#_____ Group: _____

Address: _____City: _____State_____Zip_____

Policy Holder Name: _____Relation:_____DOB_____

AUTHORIZATION AND RELEASE

Authorization for treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent. **Assignment of Insurance Benefits:** I authorize payment directly to CareMed Primary and Urgent Care PC for all benefits otherwise payable to me. **Guarantee of Payment:** I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third-party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurance, and deductibles. If you are unable to verify my insurance at time of service, I will pay in full for all services. **Release of record:** I authorize CareMed Primary Urgent Care PC to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner (s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes .**Receipt of Privacy Practices:** I acknowledged that I have received and read the notice of Privacy Practices of CareMed Primary and Urgent Care PC. I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SGNATURE: _____ **DATE:** _____
PARENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

CONSENT FOR NOTI FICATION OF TEST RESULTS / MEDICAL INFORMATION

I give permission to CareMed Primary and Urgent Care to:

1. Leave message on my answering machine: (circle one) Yes / No Cell phone # :_____
2. Follow-up phone calls or call backs regarding care at CareMed Primary & urgent Care using this phone # _____
3. Leave information with the following people _____

PATIENT SIGNATURE: _____ **Date:** _____

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I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practice:

Date: _____ Attempt: _____

Staff Name: _____