New York House Call Physicians®

DBA DOCTOR IN THE FAMILY

Revised October 2nd, 2020

DOCTOR IN THE FAMILY NEW PATIENT FORM

NOTICE OF PRIVACY PRACTICE & SECURITY: In accordance with the Health Insurance Portability Accountability Act of 1996 (HIPAA), DOCTOR IN THE FAMILY also DBA NATAN SCHLEIDER MD PLLC or NEW YORK HOUSE CALL PHYSICIANS will keep all of your health information confidential. This means that your medical records anything related to your health will NOT be released without your written consent and explicit permission.

NOTE FOR MEDICARE & MEDICAID PATIENTS: DOCTOR IN THE FAMILY does not participate with Medicare or Medicaid. Medical services covered by Medicare and Medicaid may not be billed to Medicare or Medicaid. You will not be reimbursed for services mediated by DOCTOR IN THE FAMILY.

NOTE REGARDING FEES: COMMUNICATIONS BETWEEN DOCTOR & PATIENT REQUIRING PHYSICIAN DOCUMENTATION FOR ANY REASON WILL INCUR A FEE. ***IF YOU NO SHOW FOR A SCHEDULED APPOINTMENT (BE IT IN PERSON OR PHONE OR TELEMEDICINE OR ELECTRONIC) OR FAIL TO CANCEL AN APPOINTMENT WITHIN 1 BUSINESS DAY ADVANCE NOTICE A 100% CANCELLATION FEE WILL BE CHARGED.***

DOCTOR IN THE FAMILY does NOT contract with any health insurance company but may participate with insurance company "out of network." We are not professional billers. We do not explain the meaning of the medical codes.

CHECKS MAILED TO YOU FROM INSURANCE COMPANY FOR SERVICES WE PROVIDE SHOULD BE FORWARDED TO US. YOUR CREDIT CARD MAY WILL BE BILLED FOR SERVICES PROVIDED. CHECKS MAY HAVE YOUR NAME ON THEM BUT IS NOT YOUR MONEY. MAKING MONEY BY USING YOUR INSURANCE IS INSURANCE FRAUD. AUTHORITIES WILL BE NOTIFIED. YOUR BILLS WILL BE SENT TO COLLECTIONS.

MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THE ABOVE:

Patient or Guardian Signature_____

Today's Date: _____

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Patient Name:_____

Patient Address:_____

Patient Phone Number: _____

Patient Date of Birth_____

Patient Email:_____

Patient Health Insurance Plan Name: _____

Patient Insurance Plan Member ID Number: _____

NOTE ON COMMUNICATION: EFFECTIVE, SECURE, AND TIMELY COMMUNICATIONS ARE IMPORTANT TO PROVIDE QUALITY MEDICAL CARE. PHONE, TEXT, VOICEMAIL, EMAIL, PAPER MAIL ALL MAY BE USED. ALL TEST RESULTS ARE REPORTED WHETHER NORMAL OR ABNORMAL. PLEASE NOTIFY US IF YOU HAVE HAD TESTING OF ANY KIND PERFORMED SO THAT WE MAY COLLECT AND REPORT RESULTS TO YOU QUICKLY.

PHARMACY INFORMATION:

Pharmacy Name:_____

Pharmacy Phone Number:_____

Pharmacy Address:_____

Pharmacy Address:_____

MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THE ABOVE:

Patient or Guardian Signature_____

Today's Date: _____