Caring Family Practice
225 Middle Country Rd./Suite 3
Middle Island, NY 11953

PATIENT INFORMATION FORM

Patient Information

_____
Name (Last, First, Middle)

_____
Address (Street, City, State, Zip Code)

Date of Birth ____/____/_____ Social Security Number _____-_____-_____

Gender – Circle one Male Female Home phone (____) _____-_____Cell phone (_____) _____-_____

Is the patient – Circle one Single Married Life Partner Separated Divorced Widowed

Employer: _____ Occupation: _____

Work Address: _____Work phone (____) ____ - _____X_____

Is the patient a student? Yes No If yes, name of school : _____

Spouse/Partner Information

_____
Name (Last, First, Middle)

Date of Birth ____/____/_____ Social Security Number _____-_____-_____

Employer: _____Occupation: _____

Work address: _____Work phone (_____) _____-_____X _____

Insurance Information

Insurance Policy Holder (if not the patient)

_____ _____ __ Name (Last, First,
Middle) Relationship to patient Social Security Number

_____ _____
Home Address (Street, City, State, Zip) Date of Birth

_____ _____ _____
Employer Work phone Home phone

Primary Insurance Policy

_____ _____ _____
Policy/ Insurance Company Policy/ID Number Group Number

_____ _____
Insurance Address Insurance phone

Secondary Insurance Policy (if existing)

_____ _____ _____
Policy/ Insurance Company Policy/ID Number Group Number

_____ _____
Insurance Address Insurance phone

Patient's Name (page 2 of Patient Information): _____

Referrals

I was referred to Dr. Geronimo at Caring Family Medicine by _____

Emergency Contact

_____ _____ _____
Name (Last, First, Middle) Relationship to patient Work phone

_____ _____
Home Address (Street, City, State, Zip) Home Phone

Disclosure of Medical Information

I authorize Caring Family Medicine and its medical providers to disclose medical information to:

_____ _____ _____
Name (Last, First, Middle) Relationship to patient Work phone

_____ _____
Home Address (Street, City, State, Zip) Home Phone

Messages regarding my medical information may be left at the following numbers, if desired.

_____ _____ _____
Home number Work number Cell number

Signature (patient or responsible party): _____ Date: _____

Reminder Notifications

All medical reminders (labs, follow-up appointments, tests) will be sent by e-mail. Please provide an e-mail address you would like us to send your reminders to.

_____
Personal e-mail address

Patient's Name (page 3 of Patient Information): _____

Assignment of Benefits

I authorize the release of any medical or other information necessary to process my insurance claims. I authorize Caring Family Medicine PLLC and its medical providers to apply for benefits on my behalf for services rendered by their order. I request that payment from my insurance company be made directly to Caring Family Medicine PLLC and its providers. I permit a copy of this authorization to have the full authority of the original signed copy.

Signature (patient or responsible party): _____

Date: _____

Payment Policy

All co-pays, and calculated deductible/co-insurance, are due at the time of the visit. If the decision is made to see you when you do not have your co-pay/calculated deductible/co-insurance, payment will be due within 5 business days. If payment is not received in this time, a service charge of $20 will be added.

After your insurance company has processed your medical claim, if there is any balance due from you – such as further deductible or co-insurance – we will send a statement to your home address. The balance is due upon receipt of the statement. If the payment cannot be made in full within 30 days, please contact our billing department to make payment arrangements.

If you do not have medical insurance coverage, or you are seeing the doctor for a condition that is not covered by your insurance company, full payment is due at time of service. It is the patient's responsibility to verify insurance benefits. If a financial hardship exists, payment arrangements may be made with our billing department.

In the circumstance that payment is not made by 90 days past due, and no payment arrangements have been made, your account will be sent to a collections agency. A service charge of 30% of the balance due will be added to the balance for any account sent to collections.

We extend the courtesy of accepting payment by personal check. Any personal check which is unable to be processed for payment will incur a $25 returned check fee. All future payments will be required by cash or credit card.

I have read, understand, and agree to this Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and co-insurance are my responsibility.

Signature (patient or responsible party): _____

Date: _____

Patient's Name (page 4 of Patient Information): _____

Cancellation Policy

If unable to keep a scheduled appointment, it is the patient's responsibility to cancel 24 hours prior to the appointment time. All cancellations must be made during regular business hours. The patient will be charged $30 for a routine office visit and $60 for a physical or procedure appointment not cancelled as noted above. These charges will be due at the next office visit, or by billing statement, whichever is sooner. Three non-cancelled, missed appointments may result in your dismissal as a patient.

Initial: _____

Explanation of Fees

Your fee for service includes your visit with the doctor based on the time and complexity of your condition and any treatment provided. In addition, extra time may be spent:

-Creation of a permanent medical record.
-Review of all laboratory blood test results.
-Review of prior and current x-ray or scan reports and personal review with the radiologist of abnormal studies.
-Preparation and mailing of laboratory/x-ray/scan reports to referred physicians.
-Follow-up phone calls or letter regarding laboratory test results.
-Other phone calls to and from you for various reasons.
-Referral letters to any further specialists recommended by your doctor.
-Patient educational materials and medications samples when available.
-Any research done by the doctor about your case.
-Staff assistance regarding your visit.
-Arranging and coordinating other tests and consultations.
-Calls to and from pharmacies.
-Insurance application forms: health insurance, disability insurance, life insurance.
-Insurance reports: health claims, disability claims to insurance and state, Medicare disability.
-Review and management of hospital records.
-Letters of necessity to obtain medical supplies or prescriptions.
-Tumor registry and other required reporting.
-Home health care and nursing facility orders.
-Other reports and forms: jury duty, school, job sick leave, back to work, communicable disease, etc.

In addition, the doctor participates extensively in continuing medical education and teaching to keep up-to-date on the latest medical advances.