Hemal J. Shah, MD
476 7th Street
Brooklyn, NY 11215

Patient Information

General Information:

Today's Date: _____

Gender: Male ☐ Female ☐

Mr. Mrs. Ms. Dr.

Marital Status: Circle One: Single Married Divorced Widow

Patient Name: _____
Last First Middle

Home Address: _____
Street Name City State Zip Code (County)

Date of Birth: _____ Social Security #: _____

Email Address: _____ Cell Phone #: _____

Home Phone #: _____ Work Phone # & Ext.: _____

Driver's License #: _____ Exp: _____ Secured Fax Number: _____

Employer Name: _____ Occupation: _____

Language(s) Spoken: _____ Religion: _____

Ethnicity: Circle one: Hispanic or Latino Not of Hispanic Origin Patient Declined

Race: Circle one: White/Caucasian Black/African American Asian American Indian/Alaskan Native Refused to report

Preferred Communication: Cell Phone Home Phone Work Phone Encrypted Email Message Secured Fax

Name of Referring Physician: _____ Telephone #: _____

Name of Primary Care Physician: _____ Telephone #: _____

How did you hear about us: Circle one: Referral Insurance Directory Family/Relative Newspaper Internet Phone Directory

Pharmacy Name:	Telephone Number:
Address:	
Pharmacy Name:	Telephone Number:
Address:	
Pharmacy Name:	Telephone Number:
Address:	

EMERGENCY CONTACT INFORMATION:

(1) Name: _____ Relationship: _____

Telephone Number (s): _____

(2) Name: _____ Relationship: _____

Telephone Number (s): _____

PATIENT NAME: _____ DATE OF BIRTH: _____

If the patient lives in a nursing home, please provide the name, address and telephone number of the facility:

Name of Facility: _____

Address: _____

Facility Phone #: _____ Contact Name: _____

BILLING INFORMATION (If different from patient):

Name of Person Financially Responsible for Account: _____

Relationship to Patient: _____ SSN: _____ DOB: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

GUARDIAN INFORMATION: (Please complete this portion if patient is a minor (under 18 years of age)

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Tel #: _____ Tel #: _____

Employer: _____ Employer: _____

Work #: _____ Work #: _____

HEALTH INSURANCE INFORMATION:

Name of Primary Insurance: _____

Policy #: _____ Group #: _____ Plan#: _____ Effective Date: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Social Security Number: _____

Name of Secondary Insurance: _____

Policy #: _____ Group #: _____ Plan#: _____ Effective Date: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Social Security Number: _____

Name of Tertiary Insurance: _____

Policy #: _____ Group #: _____ Plan#: _____ Effective Date: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Social Security Number: _____

PATIENT NAME: ____ **DATE OF BIRTH:** ________________________

PATIENT PHYSICIANS LIST

PLEASE LIST BELOW ALL THE DOCTORS YOU SEE ON A REGULAR BASIS:

(Example: Primary Care, Cardiologist, Nephrologist, Urologist, Obstetric/Gynecologist, etc.)

Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________	Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________
Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________	Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________
Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________	Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________
Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________	Doctor: ______________________ (First and Last Name) Specialty: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone #: ______________________ Fax #: ______________________

CONDITIONS OF REGISTRATION AND FINANCIAL POLICY

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

- PAYMENT POLICY – Payment is due in full at the time service is provided in our office.
- FOR PATIENTS WITH MEDICARE – We will bill Medicare on your behalf. As a courtesy, we will also bill secondary and tertiary insurance carriers on your behalf. You are responsible for all copays, deductibles, coinsurances, supplies and non-covered services.
- FOR PATIENTS WITH INSURANCE – All copays, deductibles and coinsurances are due at the time of service. Please be advised that your arrangements with your insurance carrier(s) are private and ultimately – you are responsible for payment.
- NON-COVERED SERVICES – Any care not paid for by your existing insurance coverage will require payment in full at the time of services are provided or immediately upon notice of insurance claim denial.
- MISSED APPOINTMENTS – In fairness to other patients and our doctors, we require at least 24 hour notice to cancel an appointment.
- RETURNED CHECKS – There will be a fee of $25.00 charged by this office for each check returned to us by your bank.

Patient Initials Here _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the vascular surgeons of Hemal J Shah, MD PC, to furnish my insurance company(ies), attorney or legal representative(s) all information in which said parties may request concerning my present illness or injury. I hereby assign the above-named physicians all monies/ benefits to which I am entitled for medical and/or surgical expenses relative to the service reported herein, but no to exceed my indebtedness to said physicians and surgeons. I appoint Hemal J Shah, MD PC to act as my authorized representative regarding my insurance, and I agree that if my claim is denied, I request that an appeal be filed. If the payment denial is overturned in appeal, I agree that the plan's payment should be paid directly to my authorized representative and direct the plan to do so in that event. I consent to and authorize the physicians at Hemal J Shah, MD PC to treat any conditions that I might have and seek treatment for. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Initials Here _____

MEDICARE PATIENTS: SIGNATURE ON FILE:

I request and authorize payments of Medicare benefits be made to Hemal J Shah, MD PC, for any services furnished to me by the provider. I authorize any holder or medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of information necessary to adjudicate the claim. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible and coinsurance, and any non-covered services.

Patient Initials Here _____

I have read, understood, and agrees to be bound by the terms of this financial policy.

_____ _____

Signature of Patient or Patient Representative Date Relationship of Patient Representative to Patient

Hemal J. Shah, MD
476 7th Street
Brooklyn, NY 11215

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Hemal J Shah, MD PC Notice or Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my Protected Health Information (PHI), Hemal J Shah, MD PC must have my consent. Therefore, I authorize Hemal J Shah, MD PC to disclose my Protected Health Information (PHI) as described on this form, to the recipients listed below: Description of the information to be disclosed (Check all that applies):

___ All Procedures ___ Sonograms/Radiology Results ___ Lab Results ___ Medical Treatments Notes

___ Others: _____

Please list the individuals who may access your protected health information (PHI):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

_____ I DO NOT authorize Hemal J Shah, MD PC to release my Protected Health Information (PHI) to anyone other than myself. I fully understand that by doing so that it may take longer to get my results.

Contact Information

I authorize Hemal J Shah, MD PC to contact me at the following numbers with results or questions:

Home #: _____ Cell #: _____ Work #: _____

May we leave results on your answering machine or voicemail? Circle one: YES NO

May we send you encrypted message regarding your results via email? Circle one: YES NO

Provide your email address: _____

May we leave appointment messages on your voice mail, answer machine or individual answering your calls? Circle one: YES NO

I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. Furthermore, I understand that this consent can be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance to this consent. This agreement shall remain in effect for 365 days from date signed.

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICAL HISTORY CONSENT FORM

By signing below, I give permission to Hemal J Shah, MD PC. to access my pharmacy benefits data electronically. This consent will enable Hemal J Shah, MD PC to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.

Patient/Representative Signature & Date Signed: _____ Relationship: _____

Witness Signature: _____ Date: _____