55 E 86TH ST, #1A
NEW YORK, NEW YORK 10028
(212) 348-3636

MY APPOINTMENT TODAY IS WITH (PLEASE CHECK):

- o DONALD ROSE, MD
- o THOMAS YOUM, MD
- o CRAIG CAPECI, MD
- o MARTIN QUIRNO, MD

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

PATIENT SOCIAL SECURITY #:_____

HOME PHONE:_____

WORK PHONE:_____

MOBILE PHONE:_____

EMAIL: _____

REFERRING PHYSICIAN:_____

REF. PHYSICIAN PHONE: _____

REF. PHYSICIAN FAX: _____

PRIMARY PHYSICIAN: _____

OCCUPATION:_____

EMPLOYER'S NAME:_____

PHARMACY:_____

EMERGENCY CONTACT:

NAME:_____

CONTACT #:_____

RELATIONSHIP:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

MEMBER ID#_____

GUARANTOR:_____

GUARANTOR DOB/SS#:_____

SECONDARY INSURANCE: _____

MEMBER ID: _____

WORKER'S COMPENSATION OR NO FAULT

DATE OF ACCIDENT:_____

INSURANCE CO. NAME:_____

INSURANCE PHONE: _____

POLICY #:_____

INSURANCE REP:_____

CASE#: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all physicians of RYC Orthopaedics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize RYC Orthopaedics to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, have been informed that the U.S. Government requires I sign this *Notice of Privacy Practices.* The privacy regulations were created by the *HIPPA Act of 1996* to protect patient privacy. I understand that the full text of the Act is available to me upon request.

SIGNATURE: _____ DATE: _____

CANCELLATION POLICY

I, the undersigned, understand that as a patient at RYC Orthopaedics I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a **$50 cancellation fee.**

SIGNATURE: _____ DATE: _____

WORKERS' COMPENSATION ONLY

You may become responsible for the medical costs of treatment for you illness or condition with the provider listed above if (1) you fail to prosecute the claim for workers' compensation or (2) It is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. **I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment. NY-WCB A9 (1-07)**

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to RYC Orthopaedics for services furnished to me by RYC Orthopaedics. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____