REGISTRATION FORM

Instructions: Fill in the blanks. Please replace any Incorrect or outdated information.

PATIENT INFORMATION

Patient Name	Sex	DOB	Age	SSN	Marital Status	IDX MRN

Address	City, State	Zip

Home Phone	Home Fax#	Cell Phone	Email Address

Employer Name	Employer Address	City, State	Zip	Work Phone	Work Fax#

Preferred Language	Ethnicity	Race
	○ Hispanic/Latino ○ Non Hispanic/Latino ○ Declined	○ Afr American ○ Natv Hawaii/Pac Isl ○ Unknown ○ Asian ○ White ○ Declined ○ Natv Amer/Alaskan ○ Other/Multiracial

Emergency Contact

Contact Name	Relationship	Home Phone	Work Phone

Physician Information

Referring Physician's Name			
Address	**City, State**	**Zip**	**Phone**

Primary Care Physician Name			
Address	**City, State**	**Zip**	**Phone**

Insurance Information

PRIMARY Insurance Name	Certificate/Policy #		Group #	Phone
Address	**City, State**			**Zip**
Insured's Name	**Relation to Insured**	**Insured's DOB**	**Effective Date**	**Expiration Date**
SECONDARY Insurance Name	**Certificate/Policy #**		**Group #**	**Phone**
Address	**City, State**			**Zip**
Insured's Name	**Relation to Insured**	**Insured's DOB**	**Effective Date**	**Expiration Date**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct North Shore LIJ Health Systems, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to North Shore LIJ Health Systems sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

(Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration snd HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim top Medicare for payment to me.

____ ____

Signature of Patient or Authorized Guardian *Date*

AUTHORIZATION TO RELEASE INFORMATION VIA E-MAIL

By providing your e-mail address you agree to receive by e-mail address information about your healthcare, including protected health information.

____ ____

Signature of Patient or Authorized Guardian *Date*

THE ZUCKER HILLSIDE HOSPITAL, A DIVISION OF NORTH SHORE-LIJ HEALTH SYSTEM
P.O. Box 38, Glen Oaks, NY 11004

Patient Name: Last_______________________________________ First____________________________________ Middle________________________

Authorized Representative:____ Relationship:___________________________________

General Consent for Treatment

I hereby consent to and authorize the physicians and/or their designees of Zucker Hillside Hospital Faculty Practice (hereinafter, the "Practitioners") to evaluate my medical condition and conduct any routine and non-invasive diagnostic and therapeutic procedures and treatments (excluding all invasive procedures and/or procedures that bear risk to life or health), which in the Practitioners' judgment are necessary for my care. I understand that I have a right to refuse any recommended treatment once it has been explained to me.

Date________________ Signature of Patient or Authorized Representative____

Consent for Release of Information to Insurance Companies and Third Party Payors

I hereby authorize and direct the Practitioners, having treated me, to release to governmental agencies, insurance carriers and/or others who are financially liable for my medical care, all information needed to substantiate payment for such care and to permit representatives thereof to examine and make copies of all records relating to such treatment to the extent necessary to process claims.

Date________________ Signature of Patient or Authorized Representative____

Assignment of Benefits to the Practitioners

I hereby assign, transfer, and set over to the Practitioners sufficient monies and benefits to which I may be entitled from governmental agencies, insurance carriers and/or others who are financially liable for my medical care to cover the costs of the care rendered to me or my dependent by the Practitioners.

Date________________ Signature of Patient or Authorized Representative____

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under the XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made either to me or on my behalf to the Practitioners. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment for such services.

Date_________________ Signature of Patient or Authorized Representative____

Financial Responsibility / Guarantee of Payment

For, and in consideration of, services rendered or to be rendered by Practitioners, I hereby guarantee payment of any bills for such services that are not covered or allowed by the governmental agencies or insurance carriers financially liable for such services.

Date_________________ Signature of Patient or Authorized Representative____

Drug/Alcohol Treatment Records

I authorize Practitioners to disclose to ______________________________*(name of person or organization to which disclosure will be made)* the following information for the following purpose(s):___Attendance / ___ Treatment Plan(s) / ___ Evaluations / ___ Lab Test Results / ___ Medical Records /
___ Diagnosis (es) / ___ Treatment Summary / ___ Other: ___________________

Specific purpose(s) of disclosure:____

In the event this authorization is utilized for payment purposes, unless otherwise indicated, I further permit the Practitioners to release any information necessary to facilitate such payment even if these items are not checked above.

I have been fully advised of the nature of the information requested prior to my signing this form. I understand that there are special federal confidentiality regulations that protect these records (42 CFR Part 2). I further understand that these regulations provide that the records cannot be disclosed or re-disclosed by the recipient without my specific written permission, except under limited exceptions stated in the regulations.

I understand that I may revoke this authorization at any time. However, I also understand that at the time I withdraw my authorization, action such as releasing information may have already occurred because I signed this form, and this is acceptable to me. Unless otherwise indicated, this authorization is valid for __________ *(specify period of time, i.e., 180 days, 1 year, etc.)* or in the event this authorization is utilized for payment purposes, until such time as payment has been completed.

Date____________________________ Signature of Patient____

Date____________________________ Signature of Patient____

THIS DOCUMENT IS TO BE FILED UNDER "DEMOGRAPHIC DATA / CONSENT"