Cohen Medical Associates

(PLEASE PRINT)

Name: _____ _____ _____ Social Security #: ____/____/____
Last Name First Name Middle Initial

Address: _____ _____ _____ _____ _____
Number and Street Apt # City State Zip

Phone Number: ( ) _____-_____ Alternate Phone: ( ) _____-_____ Cell Phone Number: ( ) _____-_____

Email Address: _____ @ _____._____ Referred by: _____

Alternate Address: _____

Dates at Alternate Address: From _____ to _____ Date of Birth: _____/_____/_____

Sex: Male or Female Age: _____ Married: _____ Single: _____ Widowed: _____ Divorced: _____

Patient employed by: _____ Occupation: _____

Primary Insurance: _____ Policy Number: _____ Copay $: _____

Policy Holder: ____Self ____Spouse ____Parent ____ Guardian

Policy Holder Name (if other than self) _____ Birthday: _____

Secondary Insurance: _____ Policy Number: _____ Copay $:_____

Policy Holder: _____Self _____Spouse _____Parent _____Guardian

Policy Holder Name (if other than self) _____ Birthday: _____

Emergency Contact and Phone Number: _____

Race: _____ American Indian or Alaska Native _____ Asian _____ Black or African American _____ Native Hawaiian or other Pacific
_____ White _____ Refuse to report

Ethnicity: _____ Non-Hispano or Latino _____ Hispanic or Latino _____ Refuse to report

Primary Language: _____ English _____ French _____ German _____ Japanese _____ Mandarin _____ Russian _____ Spanish

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Pharmacy Information

Primary Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: (_____) _____-_____

Secondary Pharmacy Name (if any): _____ Pharmacy Address: _____

Pharmacy Phone Number: (_____) _____ - _____

Cohen Medical Associates

Lifetime Authorization			Chart Number:
Indicate plan *(circle all that apply)*: Medicare Cigna United Other *(specify)*:			
Patient name *(last, first MI)*:			
Home address:	*street*		*apartment*
	city	*state*	*zip*
Social Security Number: - -	Sex (circle): M F	Date of Birth: / /	

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 Social Security Administration or its intermediary 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. I understand that I am responsible for my health insurance deductibles and coinsurance."

Signature:	Date: / /
Printed name:	HIC (Medicare) Number: - - -
If signed by anyone other than the patient, indicate relation to patient:	
If signed by anyone other than the patient, indicate reason:	

Medigap: "I request that payment of authorized Medigap benefits be made on my behalf to Cohen Medical Associates for services furnished me by Robert Cohen D.O., Douglas Colman, D.O., Lee Greene, M.D., Richard Weiss, D.O., and Chelsea Albanese, D.O. I authorize any holder of medical information about me to release to _____ *(insurance company)* any information needed to determine these benefits or the benefits payable for related services."

Signature of Beneficiary:	Date: / /
Beneficiary's printed name:	
HIC (Medicare) Number: - - -	Medigap Number:
If signed by anyone other than the patient, indicate relation to patient:	
If signed by anyone other than the patient, indicate reason:	

Insurance: "I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me."

Signature:	Date: / /
Printed name:	Contract/Policy/ID number:
If signed by anyone other than the patient, indicate relation to patient:	
If signed by anyone other than the patient, indicate reason:	

Cohen Medical Associates

Dear Patient:

It is a privilege for Cohen Medical Associates to take care of all your medical needs.

Because we participate with so many insurance companies, (hopefully including yours), we must adhere to their policies and procedures. For instance, all copays must be collected at the time services are rendered.

It is our pleasure to submit your covered medical charges to your insurance company for processing. However, this does not negate your responsibility. If your insurance company does not pay the entire allowable charge or does not respond within 45 days, ultimately, you are responsible for the remaining balance, to be paid in full. If you do not respond to our request for payment with 45 days, there will be an additional $20.00 administration fee (regardless of the amount of your balance). This helps to defray the costs of excessive billing. Any balance over 75 days will be forwarded to our collection agency. (There is also a $25.00 fee for returned checks).

Also, please note that although we have a laboratory in this office, not all insurance companies allow us to process your blood work. If your insurance company is one of those few, you have the choice of going to a lab that participates with your insurance or for a $10.00 fee; we will gladly draw your blood and send it to the appropriate lab for you. (This fee is not covered by your insurance nor is it considered your copay).

If you have any questions, please do not hesitate to ask. You may also call your insurance company, prior to services being rendered, to inquire about your specific plan benefits, deductible and copays. Patient's or authorized person's signature: I have read and understand the above information and agree to abide by the policies of both

Patient's or authorized person's signature: I have read and understand the above information and agree to abide by the policies of both my insurance company and Cohen Medical Associates. I authorize the release of any medical information necessary to process claims and also certify that the above information is correct. I authorize payment of medical benefits to Cohen Medical Associates, Dr. Robert Cohen/ Dr. Douglas Colman/ Dr. Lee Greene/ Dr. Richard Weiss/Dr. Chelsea Albanese and I hereby agree to pay any excesses not covered by insurance or in the event of no insurance. It is understood and agreed by the undersigned patient/representative that payment of all billing statements for services rendered by Dr's Cohen/Colman/Greene/Weiss/Albanese is due upon receipt. Further, in the event that litigation is commenced to collect and amount(s) owed to Dr. Cohen/ Dr. Colman/ Dr. Greene/ Dr. Weiss/Dr.Albanese, the undersigned patient/representative agrees to pay the costs and expenses of such litigation, including Dr. Cohen's/ Dr. Colman's/ Dr. Greene's/Dr. Weiss's/Dr. Albanese's reasonable attorney's fees. No expiration date.

Print Name: _____ Date: ____/____/_____

Patient's or Representative's Signature: _____

COHEN MEDICAL ASSOCIATES

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to ask how your visit was? **YES** **NO**

May we email you with general practice information and news (Newsletter)? **YES** **NO**

Please check one of the following below:

___ I hereby authorize Cohen Medical Associates to contact me by Telephone and if I am not present, you may leave a message on my answering machine or with whoever answers my phone at (_____) _____ - _____.

___ I prefer Cohen Medical Associates **NOT** speak to anyone other than me.

I hereby authorize Cohen Medical Associates to contact:

Name and Relationship: _____ Phone Number: ( ) _____-_____

Name and Relationship: _____ Phone Number: ( ) _____-_____

Patient Name: _____ Email Address: _____

Mobile Phone: _____ Home Phone: _____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____