ISLAND MEDICAL CONSULTANTS

11 Ralph Place, Suite 214
Staten Island, New York 10303
Phone: (718) 727-1898 / Fax: (718) 727-8238

PATIENT INFORMATION

Last Name:		**First Name:**		**M.I.**
Home Phone:	**Work Phone:**	**Cell Phone:**	**Referred By:**	
Address:	**City:**	**State:**	**Zip Code:**	
Date of Birth:	**Age:**	**Sex:** M U F	**Primary Language:**	**Marital Status:** S / M / W / D
E-Mail:				

Employer:		**Occupation:**	
Address:	**City:**	**State:**	**Zip:**

INSURANCE INFORMATION

Primary Insurance:	**ID #**	**Group #**	
Subscriber Name:	**Date of Birth:**	**Relationship:**	
Employer:		**Work Address:**	
City:	**State:**	**Zip:**	**Phone Number:**

Secondary Insurance:	**ID #**	**Group #**

PHARMACY

Primary:	**Address and/or Phone Number:**
Secondary:	**Address and/or Phone Number:**
Mail Order:	**Address and/or Phone Number:**

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AUTHORIZATION TO CONTACT

The specific ***TYPE OF INFORMATION*** to be disclosed is limited to emergency situations and rescheduling information. This authorization will remain in effect for one year or until termination of treatment, whichever occurs first.

The specific ***PURPOSE AND NEED*** for such a disclosure would be in the case of an emergency and to reschedule or change an appointment when there have been several unsuccessful attempts to reach the patient.

EMERGENCY CONTACTS

Name:	**Relationship:**
Phone:	

Name:	**Relationship:**
Phone:	

Is there anyone that we *CANNOT SPEAK* with?

Name:
Name:
Name:

HOW CAN WE CONTACT YOU FOR ALL *OTHER* MESSAGES?

***Note:** Appointment confirmations are only done via text message or E-Mail

1. PLEASE CIRCLE ALL THAT APPLY

HOME **CELL** **WORK** **E-MAIL / PORTAL**

2. PLEASE PROVIDE THE INFORMATION FOR THE OPTIONS CIRCLES

Home:	**Cell:**
Work:	**E-Mail:**

I understand and authorize Island Medical Consultants to contact me as stated above.

Print Name: _____ **Date:** _____

Signature: _____

MC
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CONSENT FOR TREATMENT AND AUTHORIZATIONTO BILL INSURANCE

Name: _____ Date of Birth: _____

Please read and initial each item below, then sign at the bottom.

1. _____ I certify that I am requesting the services of Island Medical Consultants for the purposes of evaluations, recommendations and treatment.

2. _____ I certify that I have been advised and have received a copy of my rights to confidentiality. I understand that these rights will be respected and upheld.

3. _____ I understand that Island Medical Consultants does NOT participate in Worker's Compensation or No-Fault / Accident Cases. There will be no documentation of such incidences and the doctors will NOT fill out paper work in connection with such incidents.

4. _____ I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to Island Medical Consultants for any services provided to me. I authorize any holder to release to my insurance company medical information about me to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.

5. _____ I understand that Island Medical Consultants will submit my insurance claims and that I will be responsible for any deductible, co-payments or client fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Island Medical Consultants cannot accept responsibility for collection of my insurance or negotiating a settlement on a disputed claim and I am responsible for payment of my account.

6. _____ I understand that my services and/or treatment with Island Medical Consultants may be terminated in the case of non-compliance. This includes non-adherence to treatment plans and instructions regarding prescribed medications; repeatedly missing appointments; or failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of this practice.

Signature _____ Date: _____

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Appointment Scheduling & Cancellation Policy

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. To do so effectively and efficiently we have developed an appointment system that sets aside ample time for each patient needs and concerns to be addressed.

To reduce the number of "NO-SHOW" and late cancellations, we have implemented an Appointment policy for booking and cancellations; and it is effective immediately.

Our policy is as follows:

1. You MUST make appointments for follow up visits; especially if any form of testing has been ordered for you, a phone call to the office to verify if we received the results is highly recommended.

2. You MUST give our office 24-Hour notice in the event you need to reschedule your appointment. This can be done by calling us at (718) 727-1898 or messaging us via our secure Medent Patient Portal.

3. If you miss an appointment without proper notice we will consider this appointment as a "NO-SHOW" and a $75.00 fee will be assessed to you. This fee will be billed to you directly and is not covered by insurance. The balance must be paid prior to your next appointment. If you do not have a scheduled appointment the balance is expected in a timely fashion and if not will be subject to collections.

4. If you are late for an appointment, our office reserves the right to reschedule the appointment.

5. If you are late for an appointment and the doctor is available to see you, you will be seen as soon as possible. Please remember we schedule an appropriate length of time with each patient, late arrival to your appointment may result in a shortened visit length.

6. Our office makes appointment reminder calls to all patients and can send reminder e-mail and text messages for patients who activate their Medent Patient Portal. It is ultimately the patient's responsibility to ensure they provide the office staff with up to date contact information.

We thank you for trusting Island Medical Consultants with your medical care.

I have read and understand the Appointment Scheduling & Cancellation policy and agree to the terms of this policy.

Print Name: _____ **Date:** _____

Signature: _____