

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:		W	Work Phone:		C	Cell Phone:			Referred By:		y:	
Address:			City:			St		State:	State:		Zip Code:	
Date of Birth:	Age:	Sex:	: MUF		P	Primary Language:		70.0	Marital Status: S / M / W / D			
E-Mail:												
Employer:					Occupation:							
Address:	City:			City:			State:			Zip:		
INSURANCE INFORMATION												
Primary Insurance:	nce: ID#			#	Group #							
Subscriber Name:	Date of Birth			te of Birth	: Relationship:							
Employer:						Work Address:						
City:	State:				Zip:			Р	Phone Number:			
Secondary Insurance: ID #			#			Group #						
				PH	ARN	1ACY						
Primary:				Address and/or Phone Number:								
Secondary:				Address and/or Phone Number:								
Mail Order:				Address and/or Phone Number:								



**EMERGENCY CONTACTS** 

11 Ralph Place, Suite 214 Staten Island, New York 10303

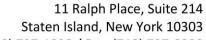
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### **AUTHORIZATION TO CONTACT**

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.

Name:	Relationship:
Phone:	
Name:	Relationship:
Phone:	
Is there anyone that we <u>CANNOT SPEAK</u> wit	:h?
Name:	
Name:	
Name:	
*Note: Appointment confirmations are  1. PLEASE CIRCLE ALL THAT APPLY  HOME  CELL	
2. PLEASE PROVIDE THE INFORMATION FO	AC AC MORNING SOCIAL MARKAGA CAMPANA SOCIAL
Home:	Cell:
Work:	E-Mail:
I understand and authorize Island Medical	Consultants to contact me as stated above.
Print Name:	Date:
Signature:	



ISLAND MEDICAL CONSULTANTS

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### CONSENT FOR TREATMENT AND AUTHORIZATIONTO BILL INSURANCE

Name:	Date of Birth:
Please read and initial each item below, th	nen sign at the bottom.
1 I certify that I am requesting for the purposes of evaluations, recom	the services of Island Medical Consultants mendations and treatment.
	vised and have received a copy of my rights ese rights will be respected and upheld.
Worker's Compensation or No-Fault / /	edical Consultants does NOT participate in Accident Cases. There will be no the doctors will NOT fill out paper work in
on my behalf, payable to Island Medica me. I authorize any holder to release to	nefits or the benefits payable for related
claims and that I will be responsible for at the time services are rendered. I und statement if my account has a balance Consultants cannot accept responsibili	due. I understand that Island Medical
Consultants may be terminated in the adherence to treatment plans and instrepeatedly missing appointments; or fa	es and/or treatment with Island Medical case of non-compliance. This includes non-ructions regarding prescribed medications; ailure to pay the fees for services rendered surance 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:		