NORTHSHORE SURGICAL SPECIALISTS
PATIENT REGISTRATION FORM

GENERAL SURGERY, BREAST SURGERY, COLON & RECTAL SURGERY
LAPAROSCOPIC ABDOMINAL SURGERY, SURGICAL ONCOLOGY, BARIATRIC SURGERY

Demographic Information

Name: ______________________ Sex: __________ Date of Birth: ______________

SS# ____/____/____ Name of Spouse ______________ Spouse DOB: ____/____/____

Referring Dr: ______________ Primary Care Physician: ______________

Email Address: ______________

Home Address: ______________ Apt. #: ______________

Town: ______________ State: ________ Zip Code: ________

Phone No. :(_____) ______-_________ Cell :(_____) ______-_________

Employer: ______________ Work :(_____) ______-_________

Spouse Employer: ______________

Insurance Information

Primary Insurance Carrier: ______________ **Carrier Phone** :(_____) ______-_________

Claim Address: ______________

Name of Insured: ______________ **Relationship to Patient:** ______________

Date of Birth: ____/____/____ **SS#:** ____/____/____

ID# ______________ Group# ______________

Secondary Insurance Carrier: ______________ **Carrier Phone** :(_____) ______-_________

Claim Address: ______________

Name of Insured: ______________ **Relationship to Patient:** ______________

ID# ______________ Group# ______________

Date of Birth: ____/____/____ **SS#:** ____/____/____

PAYMENT IS EXPECTED AT THE TIME THE SERVICE IS RENDERED. PAYMENT CAN BE MADE VIA CASH, CHECK, MASTERCARD OR VISA.

OFFICE USE ONLY

REGISTERED BY: ______________ DATE: ______________

INSURANCE CARD: ______________ DRIVERS LIC: ______________

NORTHSHORE SURGICAL SPECIALIST, M.D., P.C.
310 East Shore Road, Suite #203 Great Neck, NY 11023
Tel: (516) 482-8657 / Fax (516) 829-0002
www.NORTHSHORESURGICAL.NET

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General Surgery. Breast Surgery. Colon & Rectal Surgery
Laparoscopic Abdominal Surgery. Surgical Oncology. Bariatric Surgery

__ Dominic A. Filardi, M.D., F.A.C.S.
__ Dominick Gadaleta, M.D., F.A.C.S.
__ Larry Gellman, M.D., F.A.C.S.
__ Marc L. Greenwald, M.D., F.A.C.S., F.A.S.C.R.S.
__ Paul Katz, M.D., F.A.C.S.
__ Lewis Kurtz, M.D., F.A.C.S.
__ Howard Nadjari, M.D., F.A.C.S.
__ Angelo J. Procaccino, M.D., F.A.C.S.
__Robert J. Dring, M.D.
__Dimitra Theodoropoulos, M.D.

To the Patient: Please take a few minutes to read the following information. In today's constantly changing insurance regulations, *THIS MAY APPLY TO YOU.*

1. You may need a written authorization from you Primary Care Physician (PCP) to be examined. It is the patient's responsibility to bring the referral at the time of the office visit. You must call you PCP **PRIOR** to arriving for your scheduled appointment, so their office can generate an active referral on your behalf. (Some are paper and some are electronic) Please be aware that if you arrive without a current referral you cannot be seen and your appointment will be rescheduled.

THIS IS YOUR INSURANCE COMPANY'S POLICY… NOT OURS. KNOW YOUR INSURANCE.

2. You may also need a written authorization from your PCP for all follow-up visits. It is your responsibility to call your PCP to inquire if additional referrals are needed; the number of visits allowed and date of expiration that their office has authorized on your behalf.

3. You may need authorization from your PCP, this office or directly from your insurance company for the following: *Surgery, X-Rays, Mammography, Ultrasound, Lab Work, etc.*

4. If any surgery is to be scheduled for you, ***it is your responsibility to notify your insurance carrier and to advise them of this information.***

5. Please remember that insurance is considered a method of reimbursement for fees paid to the physician and is not a substitute for patient responsibility. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is the patient's responsibility to pay any deductible and/or co-insurance amounts and/or any other balances not paid by your insurance carrier.

6. In order to control our billing costs, we request that our charges for office visits be paid at the conclusion of each visit. If this amount is assigned to an attorney for collections, the patient and/or guarantor will be responsible for reasonable attorney fees, costs for collections, court costs and interest from the date of service.

You as the patient are ultimately responsible for your insurance and their regulations.

I have read and understood the above information.

Signature: ______________________________ Date: ____________________

I authorize the release of any information necessary to determine disability for payment and to obtain reimbursement of my claim. I request that payment of authorized benefits be made on my behalf. I assign that payment to which I am entitled, including Medicare, private insurance and other health insurance to: North Shore Surgical Specialists, M.D., P.C.

This assignment will remain in effect until revoked by this office in writing. A photocopy or facsimile of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize you to release all information to secure payment.

Signature: ______________________________ Date: ____________________

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HIPAA, PRIVACY POLICY AND PATIENT INFORMATION RELEASE FORM

1. Acknowledgement of Receipt and Patient Information Release Form

Patient/Representative Signature: ______________________________

Patient/Representative Declined to Sign: ______________________________

Print Name: ______________________________ Date: ______________

2. Patient Information Release

____
Patient's Name

I give permission to this medical office to discuss my protected (personal) health information with the following people:

____
Print Name Relationship

____
Print Name Relationship

____
Print Name Relationship

3. Patient Communication Release

I hereby authorize this medical office to verbally communicate, E-mail or fax any medical information it deems necessary (including test results, appointment confirmations and Rx orders) to any answering / mechanical device that they may encounter when contacting the specified numbers listed below:

Patient (Print Name): ______________________________

Home: ______________ Work: ______________

Cell: ______________ Fax: ______________

E-Mail: ______________ Other: ______________