NEW YORK INSTITUTE OF TECHNOLOGY
COLLEGE OF OSTEOPATHIC MEDICINE

ACADEMIC HEALTH CARE CENTER
Northern Blvd, Old Westbury, NY 11568
(516) 686-1300 Fax: (516) 686-7890

FAMILY HEALTH CARE CENTER
267 Carleton Ave, Central Islip, NY 11722
(631) 348-3254 Fax: (631) 348-3031

Patient Registration and Information Form
(Please Print)

Welcome to our Office ***Date: ___________________***

How did you hear about the health center at New York Institute of Technology? ____
Referring Provider: ____
Patient Name –***AS IT APPEARS ON INSURANCE CARD***:

(First Name) (Middle Initial) (Last Name) (Email address)

Street Address:

(City) (State) (Zip code)

Home Phone # Cell Phone #

Sex: M / F Marital Status S/M/W/D/Partner/Other Age: Birth Date:

Race/ Ethnicity (optional):____

Primary Language: ____ Do you require a translator? Yes__________ No __________

Do you have any communication issues? Yes _______ No ___________ If yes, please describe ____

Student: Yes: ____ No: ____ If Yes School attending: ____

Employer: Business Address:

Occupation: Business Phone #:

PERSON RESPONSIBLE FOR ACCOUNT (INSURANCE HOLDER):

Relationship to Patient: Birth Date:

Address if Different
Street: City: State: Zip code:

Home Phone #: Business Phone #: Occupation:

Person Responsible Employed by:

Business Address:

INSURANCE INFORMATION
Primary Insurance: Policy #

Address: Group #

Secondary Insurance: Policy #

Address: Group #

Emergency Contact:

(Last Name) (First Name) (Phone #) (Relationship to Patient)

Primary Care Physician: Phone #:

Address:

Pharmacy: Phone #:

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About Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If we are participants in your insurance see F

A. Payments for services are due at the time services are rendered (unless payment arrangements have been approved in advance by our staff). We accept MasterCard, Visa, American Express, checks and cash. In special instances we may accept assignment of insurance benefits.
B. Returned checks will be subject to collection fees.
C. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
D. You must realize, however that:
   1. *Your insurance is the contract between you, your employer and the insurance company. We are not a party to that contract*.
   2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to the companies who pay a percentage (such as 50% or 80%).
   3. Not all services are covered benefit in all the contracts. Some insurance companies arbitrarily select certain services they will not cover.
E. If you have any questions about information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

F. I hereby authorize New York Institute of Technology to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the providers all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _________________________________ ***Date***: ___________________

TERMS

I have read and understand the New York Institute of Technology financial policy and do hereby agree to assume the obligation of payment to AHCC and/or FHCC, the total fee charged for services rendered.

Signature___________________________________ ***Date***: ___________________

I understand that it is my responsibility to obtain an insurance referral (if needed by my insurance company) through my Primary Care Physician. If a referral is not obtained by the date of my visit, I am aware that I am responsible for payment.

Signature: ____ ***Date***: ___________________

MEDICARE

Under section 1842 (1) of the Medicare Act, Medicare can deny payment for services rendered. The law requires that this notification be validated with your signature.

Medicare is likely to deny payments for extensive procedures. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature: ____ ***Date***: ___________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of the Policy Holder: ___________________________ *Ins. Id. /HIC Number*: ____

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to New York Institute of Technology for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits also apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of the authorization to be used and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-38912 provides penalties for withholding this information).

Signature: ____ ***Date***: ___________________

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