ORTHOMANHATTAN
485 Madison Avenue
8th Floor
New York, New York 10022

My appointment today is with:

- ☐ O. Alton Barron, MD
- ☐ Louis W. Catalano III, MD
- ☐ Adam B. Cohen, MD
- ☐ Steven Z. Glickel, MD
- ☐ Jonathan R. Stieber, MD
- ☐ Roy I. Davidovitch, MD

PATIENT REGISTRATION

PATIENT DEMOGRAPHIC INFORMATION

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

GENDER: MALE ☐ FEMALE ☐ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ APT/SUITE: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE PHONE: _____

EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE #: _____

PHARMACY ADDRESS: _____

MEDICAL CONTACT INFORMATION

REFERRING PHYSICIAN: _____ REF. PHYSICIAN PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT:

NAME: _____ CONTACT #: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

INSURANCE: _____
MEMBER ID: _____
GUARANTOR: _____
GUARANTOR DOB/SS#: _____
SECONDARY INSURANCE: _____
MEMBER ID: _____

WORKER'S COMPENSATION OR NO FAULT

DATE OF ACCIDENT: _____
INSURANCE CO. NAME: _____
INSURANCE PHONE: _____
POLICY #: _____
INSURANCE REP: _____
CASE#: _____

HOW DID YOU FIND US?

REFERRING PHYSICIAN: ☐ FRIEND: ☐ SOCIAL MEDIA: ☐ AD: ☐ INTERNET SEARCH: ☐

OTHER: _____

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PATIENT REGISTRATION

PATIENT NAME _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign all physicians of OrthoManhattan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize OrthoManhattan to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, have been informed that the U.S. Government requires I sign this *Notice of Privacy Practices.* The privacy regulations were created by the *HIPPA Act of 1996* to protect patient privacy. I understand that the full text of the Act is available to me upon request.

SIGNATURE: _____ DATE: _____

CANCELLATION POLICY

I, the undersigned, understand that as a patient at OrthoManhattan I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a **$50 cancellation fee.**

SIGNATURE: _____ DATE: _____

WORKERS' COMPENSATION ONLY

You may become responsible for the medical costs of treatment for you illness or condition with the provider listed above if (1) you fail to prosecute the claim for workers' compensation or (2) It is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law **§**32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered**. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment. NY-WCB A9 (1-07)**

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY (NOT APPLICABLE FOR DR. ROY DAVIDOVITCH'S PATIENTS)

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to OrthoManhattan for services furnished to me by OrthoManhattan. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

I agree that OrthoManhattan may communicate with me electronically at the email address and/or mobile number provided on my demographic form. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing Orthomanhattan any updates to my email address and/or mobile phone number. I can withdraw my consent to electronic communications at anytime by calling the office.

SIGNATURE: _____ DATE: _____