Welcome to Stanley H. Schwartz, MD INC.!

Thank you for choosing Stanley H. Schwartz, MD INC as your primary healthcare provider. We are pleased that you trust us with your health needs.

Please complete the following forms to help us best serve you. The more specific you are in your responses allows us to understand your health needs better. If you have questions about any of the items on the form, please ask one of our team members to assist you.

PATIENT INFORMATION

PATIENT'S NAME		TODAY'S DATE:
SOC SEC		SEX MALE FEMALE
STREET ADDRESS		DATE OF BIRTH
CITY/ STATE / ZIP		MARITAL STATUS
HOME TELEPHONE	CELL PHONE	EMAIL ADDRESS
SPOUSE NAME	WORK PHONE	
SPOUSE BIRTHDATE	CELL PHONE	

EMERGENCY NOTIFICATION

NAME	RELATIONSHIP TO THE PATIENT	TELEPHONE

PATIENT EMPLOYMENT

EMPLOYER	TELEPHONE	OCCUPATION / PROFESSION
STREET ADDRESS	CITY / STATE/ ZIP	

INSURED PERSON/SUBSCRIBER

NAME OF PRIMARY SUBSCRIBER	TELEPHONE
STREET ADDRESS	CITY / STATE/ ZIP
RELATIONSHIP TO THE PATIENT	DATE OF BIRTH

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SECONDARY INSURANCE
ID NO. GRP. NO.	ID NO. GRP. NO.
STREET ADDRESS	STREET ADDRESS
CITY / STATE/ ZIP TELEPHONE	CITY / STATE/ ZIP TELEPHONE

THE FOLLOWING IS REQUIRED TO MAINTAIN COMPLIANCE WITH FEDERAL REGULATIONS

PREFERRED LANGUAGE	**PATIENT'S RACE**		**ETHNICITY**
☐ English	☐ Asian	☐ Native Hawaiian/Pacific Islander	☐ Hispanic or Latino
☐ Spanish	☐ White	☐ Black /African American	☐ Not Hispanic or Latino
☐ Other:	☐ Decline to State	☐ Native American/Alaskan Native	☐ Decline ☐ Unknown
		☐ Unknown	

PREFFERED PHARMACY

Local Pharmacy Name	Street/Intersection	City	Phone Number (If Known)

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

CONSENT FOR THERAPEUTIC AND DIAGNOSTIC TREATMENTS

I, _____, hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of my primary physician, Stanley H. Schwartz, MD.

Initials

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, Patient (or representative for patient) of Stanley H. Schwartz, MD, Inc. (herein known as 'Provider'), have been given a copy of the Notice of Privacy Practices (NOPP). I understand Provider may amend the NOPP at any time, and that I may obtain a copy of the revised NOPP by request. I understand that the HIPAA law grants Provider authorization to use and disclose my medical records for treatment/care and payment operations, as outlined in the NOPP.

☐ Privacy Policy refused by patient/guardian. Reason:_____

Initials

COMMUNICATION AUTHORIZATION

Provider may contact me regarding my diagnosis, results, treatment and care, or payment through mail or the following means:

	(Include Area Codes for all #s)	OK to leave message?
Home Phone:	_____	☐ Yes ☐ No
Work Phone:	_____	☐ Yes ☐ No
Cell Phone:	_____	☐ Yes ☐No
Email:	_____	

I understand that the above means of communication are NOT considered private/secure methods of communication

I understand that I may authorize Provider to share medical/billing information about my care to relatives, caretaker, close friends, etc., and shall list them below:

Name(s)	Relationship(s)	Phone #(s)

Communication authorization shall expire under the following circumstances:

1. Upon written request for records release for reason of transfer of care.
2. Upon written request by patient or legally responsible person.
3. In the case of a minor reaching the age of 18.

Initials

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

CONSENT FOR SERVICES BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

The patient and/or responsible relative or person acknowledges that he/she has been informed that a Physician Assistant or Nurse Practitioner may provide services under the direction and supervision of a Physician.

The undersign consents to authorize said Physician Assistant or Nurse Practitioner to administer and perform any and all medical examinations, treatments, diagnostic procedures and immunization against diseases which may now or during the course of the patients care be deemed advisable by the supervising physician.

Initials

ADVANCE DIRECTIVE QUESTIONNAIRE

A. Have you formulated an Advance Directive? ☐ Yes ☐ No

B. If you have formulated an Advance Directive, please check the type that you have:
□ Durable Power of Attorney for Health Care
□ California Natural Death Act
□ Living Health Care Will
□ Other: _____

C. If you have formulated an Advance Directive, you hereby agree to furnish Stanley H. Schwartz, MD, Inc. with a copy with in 90 Days.

D. If you change, amend, alter or cancel your Advance Directive, you hereby agree to notify Stanley H. Schwartz, MD and provide a copy as soon as possible so that your physician will be able to comply with your wishes.

E. Expiration of Advance Directive, if any _____.
(If the Advance Directive was formulated before 1991, it is "good" for only seven years. Advanced Directives formulated after 1991 are good indefinitely, unless you change/amend/cancel the Advance Directive)

F. I would like more information about Advance Directive ☐ Yes ☐ No

Initials

ASSIGNMENT OF BENEFITS

Please, remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures and others pay a percentage of the charges. **IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, CO-PAYMENT , OR ANY BALANCE NOT PAID BY THE INSURANCE. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISIT BE PAID AT THE CONCLUSION OF THE VISIT.** If this account is assigned to an attorney for collection and/or suit the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records. I hereby, assign all medical and /or surgical benefits to which I am entitled including Medical/ Medicaid; private insurance and other health plans to Stanley H. Schwartz, MD, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all the charges whether not paid by my said insurance. I hereby, authorize said assignee to release to my insurance all information necessary to secure payment of medical services.

Initials

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

FINANCIAL POLICY

We ask all of our patients to read and sign our Financial Policy and complete a Patient Information Form prior to seeing the doctor. All or the required signatures must be affixed in all forms requiring signatures or initial before treatment can be rendered. Affixing your signature gives our staff and health care providers consent to treat and provide health services to you us our patient.

We accept cash, checks and credit card transactions as a form of payment for services rendered. As a courtesy to you, we will assist in the processing of your insurance claim for reimbursement. However, you must understand that:

1. Your insurance policy is a contract between you and your health insurance company. We are not a party to that contract. OUR RELATIONSHIP IS WITH YOU AND NOT WITH YOUR HEALTH INSURANCE.
2. All charges incurred are your responsibility whether your health insurance pays or not. Not all services are a covered benefit in some health plans.
3. Fees for these services along with unpaid deductibles and co-payments are due at the time of service.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact them to help speed up things up.
5. If the insurance company does not pay in full within 45 days, we ask that you pay the balance due with cash, check, money order or credit card.
6. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges.

We understand that temporary financial problems may affect timely payment of your balance. Please, call our office as soon as possible when there are financial or demographic changes.

_____ _____

Signature of Patient **Date**

_____ _____

Printed Name of Person Providing Information **Relationship to Patient**

_____ _____

Signature of the Person Completing Form if Not Patient **Date**