

NEW YORK UROLOGICAL ASSOCIATES, P.C.

212-570-6800

NOEL A. ARMENAKAS, M.D.
JAMIE A. KANOFSKY, M.D.
MARA A. MONOSKI, M.D.
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MARC D. DANZIGER, M.D.
ELIZABETH KAVALER, M.D.
EDWARD C. MUECKE, M.D.

JOHN A. FRACCHIA, M.D.
ELI F. LIZZA M.D.
JON M. RECKLER, M.D.
JOHN H. WON, M.D.

Date: _____ **HOW DID YOU HEAR ABOUT US?** www.nyuurological.com WEB SEARCH
 REFERRING MD HOSPITAL REFERRAL FRIEND/FAMILY INSURANCE
 OTHER _____

Last name: _____ first name: _____ MI. _____

Address: _____ Apt: _____

City: _____ State: _____ Zip code: _____

Home #: _____ Mobile: _____ Email: _____

Office #: _____ Date of birth: ____/____/____ Sex: _____ Age: _____

Social Security#: _____ - _____ - _____ Emergency contact: _____ Phone# _____

Occupation: _____ Employer: _____

Marital status: _____ Spouse name: _____

Mother's 1st Name: _____ Father's 1st Name: _____

~ * ~

- **Primary Care Physician's Name:** _____ Email: _____
- Primary Care Contact info: _____
- **Referring Doctor's Name:** _____ Email: _____
- Referring Doctor's Contact info: _____
- **Pharmacy Information:** _____

~ * ~

Allergies: _____

Medications (Current): _____

*****BY LAW, ALL INSURANCE INFORMATION MUST BE DISCLOSED*****

- Primary Insurance _____ Member ID# _____ Group# _____
- Policy Holder's Name _____ Relationship: _____ Date of birth: _____
- 2. Secondary Insurance: _____ Member ID# _____ Group# _____
- Policy Holder's Name _____ Relationship: _____ Date of birth: _____

***Reports should go to? (if different from Referring doctor): _____ Email: _____

Address, city & state: _____ Phone: _____ Fax#: _____

880 Fifth Avenue
New York, NY 10021
Phone: 212-570-6800
Fax: 212-861-7964

955 Park Avenue
New York, NY 10028
Phone: 212-570-6800
Fax: 212-734-5762

245 East 54th Street
New York, NY 10022
Phone: 212-570-6800
Fax: 212-734-7425

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FINANCIAL POLICY

Thank you, for choosing us as your Urological health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment.

ALL FORMS MUST BE COMPLETED AND SIGNED BEFORE SEEING A DOCTOR

- **MEDICAID:** I understand that the practice is not part of the Medicaid program. As such I agree to pay for all fees incurred in my medical care provided by NEW YORK UROLOGICAL ASSOCIATES, PC or any of their doctors.
- **PRIVATE INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, **YOU ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF VISIT**
- **PARTICIPATING INSURANCE:** All co-payments and deductibles are payable at the time of visit. Your signature below authorizes payments to us for our services. You are responsible for obtaining a referral number. If you do not, you are required to pay at the time of visit as an "out of network." If your insurance does not cover a special procedure and you would like it performed anyway, you are required to sign an acknowledgement and pay at the time of service. This waives your right to submit it to your carrier for denial.
- **MEDICARE INSURANCE:** We accept assignment. We will electronically submit your claim. Medicare will mail an Explanation of Benefits to you. You can then submit this to your co-insurance. I request that payment of authorized Medicare benefits be made to me or on my behalf to NY UROLOGICAL for services furnished to me. I authorized any holder of medical information about me to be released to the healthcare financing administration agents any benefits for related services.

****MEDICARE BENEFICIARY NOTICE****

Medicare will only pay for services that it determines to be "reasonable and necessary" under 1872(a) (1) of Medicare law. I have been notified on the date indicated that **Medicare is likely to deny payment for test/treatment if I exceeded the prescribed frequency for either the prescribed test/treatment.** I agree to be personally responsible for payment if Medicare denies payment.

****RELEASE OF INFORMATION****

I hereby authorize NY UROLOGICAL to release to insurance carriers or others who are, or may be financially responsible for my medical care, all information needed to substantiate payment for my medical care. I have read the above and agree to this policy as stated.

Print Name _____ Date _____

Signature _____

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Date: _____

ACKNOWLEDGMENT AND CONSENT HIPPA

By signing below, I acknowledge that I have read the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information, and generic information, finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

1. Signature of Patient OR Patient's authorized Representative

2. Print Name of Patient OR authorized Representative

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