dsEric S. Teitel MD FACG ~ David E. Lin MD FACG

Patient Name: ____ Birthdate: _______________

Address: ____
(Street) **(City)** **(State)** **(Zip)**

Home Phone (incl. Area Code): ___________________Work: ________________ Email: ______________

Social Security #: ________________________ Spouse's Name: ____________________________
(For claim info only)

Patient's Employer Name & Address: ____
____

Emergency Contact: ____________________________________ Phone #: _____________________

INSURANCE INFO

Primary Insurance Name & Billing Address: ____
____

Your ID #: _____________________________ ***Group ID #***:___________________________________

Subscriber Name: _____________________ Subscriber Birthdate: ___________SS#: _________________
(For claim info only)

Secondary Insurance Name & Billing Address: ____
____

Your ID#: _______________________________ ***Group ID#:*** ___________________________________

Subscriber Name: _______________________ Subscriber Birthdate: ________ __SS#: ________________
(For claim info only)

****WE DO NOT BILL THIRD PARTY INSURANCES OR BILL INSURANCE COMPANIES FOR PAR INS COPAYMENTS****

****

ALLERGIES: <u>*CHECK ONE:*</u> **NO** **YES**: ____

Why are you visiting today? : ____

Primary *or* Referring Dr's Name: ______________________________ Phone: __________________
Address: ____
(Street) **(City)** **(State)** **(Zip)**

Does your Insurance require referrals? Yes No. Which one? _____________ **Does your Insurance require separate authorizations for certain services? Yes No**. Which one? __________ If yes, what services? ***Please list***: ____

* *I herby authorize direct payment of all Commercial/ Medicare/ Medicaid Medical and/or Surgical Benefits to Dr Eric S. Teitel MD PC for services rendered by him in person or under his supervision, and authorize the release of all medical info necessary to obtain such payment(s). I understand that I am fully responsible for any balance* ***<u>NOT COVERED</u>*** *by my insurance.*

Signature: ____ Date: ______________________

Important Notice: Insurance & Office Policy

For your convenience, the office of Dr. Eric S. Teitel, MD, PC, participates with numerous insurance carriers. Under the rules of these contracts, our office agrees to accept and treat you for the allowable benefits of your plan.

PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR:

- ❑ Having you insurance card with you to this office. ANY CHANGES in coverage or ID cards are MUST BE brought to the Receptionist's attention immediately.
- ❑ Bringing your referral/Authorization # from your primary care physician. If not, you will be required to sign a waiver, which will make you responsible for the ENTIRE visit amount if we do not receive it in our office in 48 hours. Don't count on your PCP to fax it "prior to". They are bogged down with these requests daily!
- ❑ Keeping track of the number of visits per referral, and services authorized.
- ❑ Making sure any procedures have been precertified, if needed.
- ❑ Letting the Nurse know whom your participating LAB is if you need blood work/biopsies taken. If we do not receive this information from you, and we send it to the wrong LAB, you will be responsible for that bill. ***MY LAB IS:** ____.
- ❑ Paying copay/co-ins at the time of each visit. Past due balances WILL be sent to COLLECTIONS!
- ❑ A $20 fee on all returned checks.
- ❑ Giving a MINIMUM of 24-hour cancellation notice for all appointments. Failure to do so will result in a CHARGE TO YOU OF $50 FOR OFFICE VISITS, AND $200 FOR PROCEDURES! We do not overbook, so availability is at a premium. It isn't fair to other patients who would have otherwise needed your slot. In addition, we have outside anesthetists who come to serve you, and this disrupts their schedule.
- ❑ Any claims not paid or responded to by your carrier(s) over 1 year.

PRESCRIPTION_REFILLS:

All patients must have been seen by the Doctor within the LAST 6 MONTHS depending on type of prescription requested, but NOT LONGER THAN 12 MONTHS. Due to prior problems encountered, PRESCRIPTIONS WILL NOT BE PHONED IN TO PHARMACIES. We will be happy to mail it to your home, or hold it for pick-up at our office. This way we are assured that our patients will receive their meds. DO NOT WAIT UNTIL YOU HAVE 3 DAYS LEFT ON YOUR PRESCRIPTION! WE CAN'T GUARANTEE THAT YOU WILL GET IT ON TIME. The Doctor must review all medications, and he may not be available to okay it in time.

TEST_RESULTS:

Are CONFIDENTIAL and will only be given to you unless you have otherwise personally authorized differently. Spouses, relatives, and friends will have to have prior approval from you, and in writing, to this office. Calls for results will be returned AFTER 2 pm.

Unfortunately, with the changes in today's healthcare system, the burden falls to you, our patient, to know and understand your health insurance coverage. Your insurance is a contract between you, your employer, and the insurance company. We wholeheartedly appreciate your assistance in helping us to properly file your claims. Thank you.

Signature: ____ Date:

Eric S Teitel MD PC
Cortlandt Manor & Carmel NY

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I ______________________________________, hereby authorize **Dr. Eric S Teitel MD PC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Drs. Teitel /Lin** can refuse to treat me.

I have been informed that **Drs. Teitel/Lin** has prepared a notice ("Notice") that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Drs. Teitel/Lin** in writing, but if I revoke my consent, such revocation will not affect any actions that **Drs. Teitel/Lin** took before receiving my revocation.

I understand that **Dr. Eric S Teitel MD PC** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Drs. Teitel/Lin** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Dr Teitel does not have to agree to such restrictions, but that once such restrictions are agreed to, **Drs. Teitel/Lin** must adhere to such restrictions.

______________________________________ ________________

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

____

Printed name of patient or patient's representative

____

Relationship to the patient

Eric S. Teitel M.D., F.A.C.G.
David E. Lin M.D., F.A.C.G.

1985 Crompond Rd. Ste. Upper E
Cortlandt Manor, NY 10567
Phone: 914-734-8224
Fax: 914-734-4891

1071 Stoneleigh Ave.
Carmel, NY 10512
Phone: 845-228-5385
Fax: 845-228-5392

HIPAA Consent for Release of Medical Information
to spouse, relatives or friends

I, ___________________________ hereby give my permission to ***Dr. Teitel/Dr. Lin***,
(patient name)

to *disclose private medical information* if I am *unavailable or incapacitated* for any

reason to :__________________________ . This party is my ______________________.
(name of recipient(s)) **(relationship to patient)**

This includes excludes HIV-AIDS information. This agreement will remain in effect until I advise the disclosing entity in writing.

This agreement will remain in effect until I advise the disclosing entity in writing.

____
(patient signature)

____
(witness)

____
(today's date)

cc: chart

Facility Fee Patient Waiver Form

Date: ______________________

Patient Name: _________________________________ DOB: ____/____/_____

Facility Name: **Cortlandt Medical Endoscopy OBS PC______**

Surgeon Name: **Eric S. Teitel MD / David E. Lin MD_______**

If you should have a procedure performed at our location, please note that because the above facility has met and maintains the highest level of the safety requirements necessary to receive accreditation through **JCAHO**, there may be two separate claims submitted to your insurance company.

I understand that the insurance payment for the facility fees associated with office based procedures, may be sent to me, as this facility ***MAY NOT*** *be contracted with my insurance carrier, even though the professional services may be.*

Because of this, ***I agree to endorse and forward any payment or non-payment,*** along with the Explanation of Benefits and all other documents I receive from my insurance carrier to the below central billing office.

This agreement does not waive or abrogate any financial responsibility I may have for the professional services provided by the above surgeon. Any deductible, co-payment or other amount that my insurance company considers to be my responsibility will be paid directly by me to the surgeon's office.

Name: ____________________________________ Date: _________________

Signature: ________________________________

Kindly mail the endorsed insurance check and all documents to:

Cortlandt Medical Endoscopy OBS PC
1985 Crompond Rd Ste E
Cortlandt Manor, NY 10567

Billing Dept: Attach this completed and signed form with facility billing information.

UNIVERSAL MEDICATION FORM

Date form started:

Name:	**Allergies:**
Birth Date:	
Phone Number:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: 1) **Prescription and over-the-counter medications (examples: aspirin, antacids herbals (examples: ginseng, gingko), and vitamins.** Include medications taken as needed (example: nitroglycerin). Please also include if yo **received any injections recently**, i.e. steroids. **2**) CROSS OFF any medications you no longer take. **3**) **Keep a copy of this card with you** at all times. Show this card to every doctor visit on every visit, every visit to an emergency room and on admission to any hospital. **4**) **NEVER** tak drugs prescribed for someone else.

OFFICE USE ONLY

DATE PRESCIBED:	MEDICATION /VITAMIN/ DOSE	DIRECTIONS: (How many times a day do you take this and when.)	Medication held due to procedure		DATE STOPPED	Notes: **Reason for taking / Doctor Name**	**Name of Medication in Office**	Contra-indicated'	
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No
			Yes	No				Yes	No

Patient Signature if applicable_________________________________ Date__________20____

Responsible Adult Signature__________________________________ Date__________20____

Signature of representative of organization accepting the patient___________________________________ Date_____

Updated: (List all dates updated)

____________________ ____________
Patient/Guardian Signature Date

____________________ ____________
Organizational Rep Signature Date

____________________ ____________
Patient/Guardian Signature Date

____________________ ____________
Organizational Rep Signature Date

ERIC S. TEITEL MD PC
Eric S. Teitel MD FACG & David E. Lin MD FACG

Your Name____
Date_________________________

INITIAL LEARNING ASSESSMENT

During your visit with our organization you will be presented with information that may be new to you. To aid in providing the best care possible please answer the following questions. Then return this form to the front desk. Thank you.

How do you like to learn new things? Please check all that apply

	Reading		Pictures/Diagrams
	Discussion		Hands On/Demonstration
	Videotapes		Self-study
	Audiotapes		Other

Factors that can affect learning:	**Yes**	**NO**	**Comments**
Do you speak English in your home?			If no, what language do you speak? Name of interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? ☐ Yes ☐ No
Do you see well?			If no, do you utilize glasses or contacts? ☐ Yes ☐ No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If Yes, explain

Other comments

____

____

____
PATIENT SIGNATURE

<u>PHARMACY INFO</u>

Patient Name: ________________________________ Birth Date: _________________

Pharmacy Name (circle one): A&P CVS ECKERD HANAFORDS JNR MEDCO

RITEAID SHOP RITE STOP & SHOP WALGREENS

WALMART OTHER: __________________________

Pharmacy Address: _________________________ City: ________________ State: _____

Pharmacy Phone: ___________________________ Fax: ___________________________

*****Staff only: Please load Rx info onto Practice Fusion eScribe*****