DIGESTIVE DISEASE CARE | DDC Advanced. Comprehensive. Personalized.

915 Hillside Ave, New Hyde Park, NY, 11040
68-45 Main Street, Flushing, NY, 11367
104-40 Queens Blvd Suite 1F, Forest Hills, NY, 11375
1991 Marcus Ave Suite M200, New Hyde Park, NY 11042
380 S Broadway Hicksville, NY 11803

Registration Form

Title (circle one) : Mr. Ms. Mrs. Miss Dr. NP PA Other: ____ **Which LAB do you use?** _____

First Name: _____ **M:** _____ **Last Name:** _____

Gender (circle one): Male Female Other **Marital Status (circle one):** Single Married Separated Divorced Widowed Partnered

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Address: _____ **Apt #**_____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ___ ___ ___-___ ___ ___-___ ___ ___ ___ **Cell Phone:** ___ ___ ___ -___ ___ ___ -___ ___ ___ ___

Emergency Contact: Name:_____ **Relationship:** _____ **Phone:** ___ ___ ___-___ ___ ___-___ ___ ___ ___

Email (print clearly): _____

Work Status (circle one): Employed Unemployed Self Employed Part-time Student Full-time Student Retired Disabled

Ethnicity: _____ **Religion:** _____

Preferred Language: _____ **Race:** _____

How did you find us? **Primary Care Physician** **ZocDoc** **Media** **Online** **Other:** _____

Primary Care Physician: **Name:** _____ **Phone Number:** __ __ __ -__ __ __-__ __ __ __

Address: _____ **City:** _____ **Zip code:** _____

Referring Physician: **Name:** _____ **Phone Number:** __ __ __ -__ __ __-__ __ __ __

Pharmacy: **Name:** _____ **Phone Number:** __ __ __ -__ __ __-__ __ __ __

Address: _____ **City:** _____ **Zip code:** _____

Primary Insurance: _____ **Name of Policy Holder:** _____

DOB of Policy Holder: __ __/ __ __/ __ __ __ __ **Effective Date:** __ __/ __ __/ __ __

Secondary Insurance: _____ **Name of Policy Holder:** _____

DOB of Policy Holder: __ __/ __ __/ __ __ __ __ **Effective Date:** __ __/ __ __/ __ __

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDARIES OR CARRIERS, OR TO THE PHYSICIAN'S OFFICE OR TO MY ATTORNEY OR OTHER DOCTOR'S OFFICE. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO DIGESTIVE DISEASE CARE P.C. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

SIGNATURE: _____ **DATE:** __ __/ __ __ / __ __ __ __

TURN PAGE

Patient Name: _____

Patient Date of Birth: __ __ / __ __ / __ __ Patient SSN: __ __ __ - __ __ __ - __ __ __ __

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

NOTICE TO PATIENT:

BY SIGNING THIS FORM, YOU GRANT US CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH CARE INFORMATION FOR THE PURPOSES OF **TREATMENT**, VARIOUS ACTIVITIES ASSOCIATED WITH **PAYMENT** AND **HEALTH CARE OPERATIONS.** OUR **NOTICE OF PRIVACY PRACTICES** PROVIDES MORE DETAILS ON OUR TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS. IF THERE IS NOT A COPY OF THE NOTICE ACCOMPANYING THIS CONSENT FORM, PLEASE ASK FOR ONE. WE ENCOURAGE YOU TO READ IT SINCE IT PROVIDES DETAILS ON HOW INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND DESCRIBES CERTAIN RIGHTS YOU HAVE REGARDING YOUR HEALTH CARE INFORMATION.

AS STATED IN OUR **NOTICE OF PRIVACY PRACTICES,** WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES. IF WE SHOULD DO SO, WE WILL ISSUE A REVISED NOTICE. SINCE REVISIONS MAY APPLY TO YOUR HEALTH CARE INFORMATION, YOU HAVE THE RIGHT TO RECEIVE A COPY BY CONTACTING OUR PRIVACY OFFICER.

YOU HAVE THE RIGHT TO **REVOKE** YOUR CONSENT BY GIVING WRITTEN NOTICE TO OUR PRIVACY OFFICER. THE REVOCATION WILL NOT AFFECT ACTIONS THAT WERE ALREADY TAKEN IN RELIANCE UPON THIS CONSENT. YOU SHOULD ALSO UNDERSTAND THAT IF YOU REVOKE THIS CONSENT WE MAY DECLINE TO TREAT YOU.

YOU ARE ENTITLED TO A COPY OF THIS **CONSENT FORM A**FTER YOU HAVE SIGNED IT.

I, _____, have read the Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment and health care operations.

_____ **DATE: _____/ _____ / _____**

Patient's Signature or Signature of Patient's Representative

_____ _____

Print Patient's Name or Name of Patient's Representative Relationship to Patient

E-MAIL RELEASE

I, _____ (or Patient's Representative) want to communicate via e-mail with (Digestive Disease Care PC) on matters related to my health and/or my medical treatment. I understand that any Confidential Health Information I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentially associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

_____

Print Patient's Name or Name of Patient's Representative

_____ **DATE: _____/ _____ / _____**

Signature of Patient or Patient's Representative

TO BE COMPLETED BY OFFICE

_____ _____

(Witness: Print Name) (Signature of Witness)

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Sejal Sharma Practice Address: 915 Hillside Ave New Hyde Park, NY, 11040 Phone: 516-437-9000 Fax: 347-236-3163