SCOTT M. PRESS, MD, PC
MEDICAL REGISTRATION FORM

(Patient Information Form – please fill out in its entirety)

PATIENT INFORMATION			
Last Name:	**First Name:**	**Date:**	
Date of birth:	**Gender: Male _______ Female ______**		
VISIT INFO			
Is today's visit accident or work related?			
How did you hear about us? (TV, Newspaper, Physician, etc)			
Pharmacy:	**Store No. (if known):**	**Phone:**	
Address:	**City:**	**State:**	**Zip Code:**
Referred By: **(REQUIRED FOR MEDICAL CLEARANCE APPOINTMENTS)**			
PATIENT INFORMATION (DEMOGRAPHICS)			
Current address:	**City:**	**State:**	**Zip Code:**
Home Phone: **Is it okay to leave a message?**	**Work Phone:** **Is it okay to leave a message?**	**Cell Phone:** **Is it okay to leave a message?**	
PLEASE CIRCLE PREFERRED TELEPHONE NUMBER ABOVE			
Email Address:	**Social Security:**		
Do you have a CHS EPIC MyChart Account?			
GENERAL INFORMATION			
Language: **Do you require an interpreter?**	**Marital Status: S M D W**		
Ethnicity: (Please check) ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Do not wish to provide			
Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White			
Religion:	**Do you work for Catholic Health Services of Long Island(CHSLI):**	**Do you have any relatives that work for CHSLI:**	
PRIMARY CARE PROVIDER INFORMATION			
Who is your Primary Care Provider:			
PATIENT RELATIONSHIPS/EMERGENCY CONTACT INFORMATION			
Emergency Contact Name:	**Phone:**	**Relation:**	
Address:	**City:**	**State:**	**Zip:**

EMPLOYMENT INFORMATION (PATIENT)			
Employment Status: **F/T____ P/T_____ Student____** **Retired___ Unemployed____**	**Employer:**		
Employer address:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

INSURANCE INFORMATION			
Primary Insurance:	**Group No.:**	**Secondary Insurance:** **(Only if Appicable)**	**Group No.:**
Patient Relationship to Subscriber: (Please check) ☐ **Self** ☐ **Spouse** ☐ **Father** ☐ **Mother** **Other**		**Patient Relationship to Subscriber: (Please check)** ☐ **Self** ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other**	
Subscriber ID:		**Subscriber ID:**	
Subscriber Name:	**Date of Birth:**	**Subscriber Name:**	**Date of Birth:**
Subscriber Address:	**SSN:**	**Subscriber Address:**	**SSN:**

EMPLOYMENT INFORMATION (POLICY HOLDER)			
Employer:	**Employment Status:** **F/T____ P/T_____ Student____** **Retired___ Unemployed____**	**Date of Retirement:**	
Employer address:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

GUARANTOR INFORMATION (PATIENT 18 YRS AND OLDER)			
Guarantor Name:			
Date of birth:	**SSN:**	**Phone:**	
Guarantor Address:	**City:**	**State:**	**Zip Code:**
City:	**State:**	**Zip Code:**	
Phone:	**Fax:**	**Email:**	

Signature: ____ Date:______________________________

Signature on File, Assignment of Benefits, Financial Agreement

BENEFICIARY NAME (print):		DATE OF BIRTH:	

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Scott M. Press, MD, PC for services furnished me by Scott M. Press, MD, PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Scott M. Press, MD, PC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. My signature authorization will remain on file unless I revoke authorization in writing.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Scott M. Press, MD, PC, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Scott M. Press, MD, PC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Scott M. Press, MD, PC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Scott M. Press, MD, PC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **CLAIMS AUTHORIZATION:** I authorize payment of medical benefits directly to Scott M. Press, MD, PC for services rendered.

5. **OTHER INSURANCE:** I understand that Scott M. Press, MD, PC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Scott M. Press, MD, PC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Scott M. Press, MD, PC if I belong to a plan that does not appear on the above mentioned list.

6. **NON-COVERED SERVICES:** I understand that Scott M. Press, MD, PC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Scott M. Press, MD, PC will provide me with an Advanced Beneficiary Notice for services that they suspect will not be covered, and I will be given the option to accept or decline said services. Accordingly, the undersigned accepts full financial responsibility for services that I have agreed to as reflected on the ABN, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Scott M. Press, MD, PC to obtain necessary health care service plan authorizations.

7. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Scott M. Press, MD, PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Scott M. Press, MD, PC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, is hereby assigned to Scott M. Press, MD, PC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Scott M. Press, MD, PC. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

____   __________________________

Beneficiary Signature or Authorized Party   Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities 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-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

____________________________________ ____________________________________

Signature of Patient or Personal Representative | Print Name of Patient or Patient Representative

____________________________________ ____________________________________

Description of Personal Representative's Authority | Date

____________________________________ ____________________________________

Signature of Facility Representative | Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare obligations, S.W. Suffolk Medical may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit S.W. Suffolk Medical to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

____________________________________ ____________________________________

(relationship to me)

____________________________________ ____________________________________

(relationship to me)

I expressly permit S.W. Suffolk Medical to disclose my protected health information for the purposes of appointment/test/procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel#__________________________ Office voicemail: Tel#__________________________

Other (specify):__________________________________ Tel#_______________________________________

____ ____________________________________

Signature of Patient/Personal Representative/Parent/Guardian | Date

635 Belle Terre Road, Suite 106-Port Jefferson, NY 11777-Ph (631) 675-2810; Fax (631) 675-2812
792 Harrison Avenue-Riverhead, NY 11901-Ph (631) 591-3120; Fax (631) 591-3123

EPIC MSPQ QUESTIONARE FORM

PART 1

1. Are you receiving Black Lung (BL) Benefits? □ Yes or □ No
2. Are the services to be paid by a government research program? □ Yes or □ No
3. Are you entitled to benefits through the department of Veterans Affairs (DVA)? □ Yes or □ No
   Has the DVA authorized and agreed to pay for your care at this facility? □ Yes or □ No
4. Was the illness/injury due to a work related accident/condition? □ Yes or □ No If no, go to Part 2
   Date of injury/illness:________________________________ Policy or ID #:___________________
   Workers' compensation plan name:_____________________ Employer name:__________________
   Plan address: Employer address:

   City: ______________________ City: __________________________
   State: _______ Zip: __________ State: _______Zip: _______________

PART 2

1. Are you entitled to Medicare based on Age?: □ Yes or □ No
2. Are you entitled to Medicare based on Disability? □ Yes or □ No
3. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)?: □ Yes or □ No

PART 3

1. Are you currently employed ? □ Yes or □ No If applicable date of retirement:_______________

   Employer name:_________________________ City:_____________________________________

   Employer address: State:_____________ Zip:___________________

2. Do you have a spouse who is currently employed: ? □ Yes or □ No
   If applicable date of retirement:_______________

   Employer name:_________________________ City:_____________________________________

   Employer address: State:_____________ Zip:___________________