



**Scarsdale Medical Group
DEMOGRAPHIC FORM**

PLEASE COMPLETE ALL INFORMATION & BRING TO BILLING

First Name _____ MI _____ Last Name _____
Home Address _____ Apt/Suite# _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Emergency Name _____
Emergency Phone _____ Emergency Relationship _____
Fax _____ E-mail _____
Date of Birth _____ Sex _____ SSN _____
Marital Status: _____ Race _____ Ethnicity: _____
Primary Language _____
Appt Doctor _____ Referring Doctor _____

I designate the following persons listed below as a person or persons involved with my healthcare and/or payment (circle as applicable):

Name: _____ Relationship: _____ Health Info: Yes/No
Payment Info: Yes/No

Name: _____ Relationship: _____ Health Info: Yes/No
Payment Info: Yes/No

Name: _____ Relationship: _____ Health Info: Yes/No
Payment Info: Yes/No

Name: _____ Relationship: _____ Health Info: Yes/No
Payment Info: Yes/No

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Home Telephone | <input type="checkbox"/> Detailed Message | <input type="checkbox"/> Call back Number Only |
| <input type="checkbox"/> Work Telephone | <input type="checkbox"/> Detailed Message | <input type="checkbox"/> Call back Number Only |
| <input type="checkbox"/> Cell Telephone | <input type="checkbox"/> Detailed Message | <input type="checkbox"/> Call back Number Only |
| <input type="checkbox"/> Mail to Home Address | | |
| <input type="checkbox"/> Mail to Work Address | | |

Please review the following statements

Financial Policy and Insurance Authorization

I authorize Scarsdale Medical Group LLP (“Group”) to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, and to any other insurance or managed care company covering me or my dependents or insurance beneficiaries, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare, insurance or managed care benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to the Group. If my insurance plan will not assign benefits to the Group, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan. I understand that I am responsible for all deductible, co-payment and co-insurance amounts and for all non-covered services. I further understand and agree that if my insurance plan sends payment to me rather than the Group, I will immediately endorse the check to the Group and forward it to the Group to be cashed and applied to my account.

Consent To Use and Disclose Protected Health Information For Treatment, Payment and Health Care Operations

I hereby consent and authorize the Group to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, by and to its workforce members, health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of the Group.

I understand that, for example, my health information may be used or disclosed by the Group to: provide for my care and treatment, including the filling and supplying of prescriptions; communicate among various health care professionals who are involved in my care or treatment; obtain payment for care and treatment provided by the Group; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand the Group's HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information. I understand that the Group has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, the Group will post a new notice in the office. I may contact the Group at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

Designation of Disclosure

I agree that the Group may disclose my protected health information to a family member, close personal friend, or other caregiver, who is involved with my healthcare and/or payment relating to my healthcare. In that case, the Group will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare, unless I request otherwise.

As required under HIPAA (Health Insurance Portability Accountability Act), we have an ongoing commitment to protect the privacy of our patients' personal and medical information. A front desk staff member will ask to scan your current insurance card, and driver's license or other government issued picture ID. If the patient is a minor, the patient's parent or guardian should present this information. Information concerning a patient's course of treatment will only be released to the patient or to specifically designated family members, friends, or caretakers. Therefore, if you would like a family member, friend or caretaker to be able to obtain information regarding your treatment, you must list each individual on Scarsdale Medical Group, LLP's Designation of Disclosure form.

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information.

Acknowledgement and Agreement to the terms and conditions of this document:

Patient's Name _____ Date: _____



Administrative Office

550 Mamaroneck Avenue
Suite 302 Harrison NY 10528
T: 914.723.8100
F: 914.513.2785

Compassion, Confidence and Commitment for over 50 Years

www.scarsdalemedical.com

Signature _____
(Patient/Parent/Guardian)

Printed Name _____
(Patient/Parent/Guardian)