NEW GENERATION MEDICAL, PC

Patient's Name____ **Social Security #:** ______-______-_______ **Date of Birth** ____/_____/_____**Sex** ___
Last First

Home # (______) ______-__________ **Cell #** (______) _______-__________ **Pharmacy Phone #** (______) _______-__________

Address____ **City**______________________ **State**______ **Zip**_____________

Email____ **ALLERGIES**____**Referred by?** ____________________

Emergency Contact____ **Relationship**__________________________ **Phone #** (______) _______-__________

I ______________________________, certify the above information to be correct. I understand that I am responsible for payment of all fees for the services rendered, including those services denied for any reason by my insurance company I understand that this office maintains the right to bill all my insurance carriers for their services provided.

Signature of patient (or parent if patient is a minor) ______________________________________**Date** ___________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, ______________________________, have received a copy of New Generation Medical, PC's Notice of Privacy Practices.

Signature of Patient: ____ **Date** _________________________________

PATIENT CONSENT FORM

I hereby give my consent for **New Generation Medical PC** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). **New Generation Medical, PC**'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this Consent. **New Generation Medical, PC** reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **New Generation Medical, PC** at **4766 Bedford Avenue, Brooklyn, NY 11235.**

With this Consent, **New Generation Medical, PC** may call to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this Consent. **New Generation Medical, PC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked **Personal and Confidential.**

With this Consent, **New Generation Medical, PC** may e-mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that **New Generation Medical, PC** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions but if it does, it is bound by this Consent.

By signing this Consent, I am consenting to **New Generation Medical. PC**'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, or later revoke it, **New Generation Medical, PC** may decline to provide treatment to me.

AGREED:

Signature of Patient: ____ **Date** _________________________________

CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) an immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient: ____ **Date** _________________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of authorized Medicare/other insurance company benefits be made on my behalf to New Generation Medical, PC for any services furnished to me by that party which accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party that accepts assignment l understand it is mandatory to notify the health care provider of any other party that may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 38/01-3812 provides penalties for withholding this information.)
I request that payment under the Medicare or other medical insurance program(s) be made to New Generation Medical, PC for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by New Generation Medical, PC from Medicare and/or other insurance company(ies), I will immediately endorse them and turn them over to New Generation Medical, PC for services rendered.
I understand that I am responsible for payment of all charges and fees to New Generation Medical, PC to which they are entitled to collect which are not paid for by Medicare or other insurance.

Signature of Patient: ____ **Date** ________________________________

POLICIES

Prescription Renewal Policy
New Generation Medical, PC's physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the nurses between the hours of 8 am and 5 pm., Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality of medical care.

Patient Examination Room Escort Policy
To ensure your comfort, at your request, you may have an escort present with you during your examination. An escort may be a friend or a family member, or we can furnish a nurse from our staff to be present during your examination. At the physician's discretion, an escort may also be asked to be present at the time of the examination.

To maintain your good health, it is important to us that you, our patient:

- Not smoke
- Lose weight (if necessary)
- Maintain your optimum weight
- Exercise daily walk, swim, etc.
- Follow a healthy diet:Decrease — Cholesterol, calories, saturated fats use salt substitutes
- Do not use alcohol or use in moderate amounts only
- Use your safety belts
- Use child safety belts
- Wear your bicycle helmet
- Get regular mammograms and pap smears (start paps with onset of sexual activity or age 18 years)
- Have yearly eye exams
- Stop use of illegal drugs, marijuana, and designer drugs
- Use safe sexual practices HIV protection, venereal diseases
- Regular prostate exams for the older male

Signature of Patient: ____ **Date** ________________________________