Life Steps OB/GYN *Health Care for Women, LLP*

60 EAST END AVENUE, NEW YORK, NY 10028 PHONE: (212)860-4800 FAX: (212)860-4891

Patient Information

Patient Name:____
(Last) (First)

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

Date of Birth:____________________ Employer:____________________

S.S#____________________ Occupation:____________________

Home #____________________ Marital Status:__________

Cell #____________________

Work#____________________ **What is your preferred mode of contact?

Email____________________ ____________________

Pharmacy#____________________ How did you hear about us?

____

Spouse or Emergency Contact

Name: ____________________ Phone# ____________________
Address: ____
(Street) (City) (State) (Zip)

Primary Care Physician

Name:____________________ Phone#____________________
Address:____
(Street) (City) (State) (Zip)

Primary Insurance Information

Company Name: ____________________ Phone#____________________
Address:____
(Street) (City) (State) (Zip)

Policy ID ____________________ Group # ____________________

Policy Holder Name(Insured):____________________ ( )Spouse ( )Significant ( ) Parent/Guardian

Insured's Date of Birth ____________________ Insured's S.S# ____________________

Insured's Employer: ____________________

Insured's Occupation:____________________

Secondary Insurance Information

Company Name: ____________________ Phone # ____________________
Address:____
(Street) (City) (State) (Zip)
Name of Insured:____________________ Relationship to Insured:____________________
Policy #____________________ Group # ____________________

ASSIGNMENT AND RELEASE: I, the undersigned, give my authorization to treat and assign directly to Life Steps OB/GYN Healthcare for Women, LLP, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

____________________ ____________________ ____________________
Patient Signature Relationship to Patient, if not patient Date

NOTICE OF PRIVACY PRACTICES

As required by"HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, and billing or collection activities and utilization review. An example of this would be sending a bill for or visit to your insurance company for payment.

HEALTH CARE OPERATIONS includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that writing request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with rights with respect to your protected health information, which you can exercise by presenting a written request to our privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protect health information.

I have read and understand the above privacy policy.

Name: ______________________________

Signature: ___________________________

Date: _______________________________