PATIENT INFORMATION (Please Print) Today's Date _____/_____/_____

Name ____ Date of Birth: _____/_____/_______
Last First M.I. Month Day Y ear

Mailing Address: __________________________________ Apt# _______ SS#: _____-____-________
City State Zip

Home Phone: (____) _____________ Work Phone: (____) __________Ext_____ Cell Phone: (____) _____________
Area Code Area Code Area Code

Pharmacy Name ___________________Pharmacy Addr: ____________________________Pharmacy Tel #. ___________

Email ____________________________ Age: _______ Sex (M/F): ________ Marital Status: _____________

Primary Care Physician ____(___)_____________
Name Address Phone

In case of emergency:

Spouse Name ____ Phone ( ) ________________

Nearest Relative (not living with you)______________________ Phone ( ) ________________

Friend (not living with you) ________________ ______________ Phone ( ) ________________

Whom may we thank for referring you to us:________________________________ Phone ( ) ________________

PRIMARY INSURED PARTY OR PARENT (if different from patient)

Name ____________________________________ ____Date of Birth: ____/_____/_____ SS#: _____-____-_____
Last First M.I. Month Day Y ear

Mailing Address: ____ Insured's Id: ________________
Apt# City State Zip

Sex (M/F): ______ Home Phone: (____) _______ Work Phone: (____) _______ Other Phone: (____) _________

INSURANCE INFORMATION (Please present insurance card at time of check-in.)

Primary Insurance Name ________________________ **Secondary** Insurance Name _______________________

Name of Insured ______________________________ Name of Insured ________________________________

Insured's ID# _________________ Group # ________ Insured's ID# _________________ Group # ________

Relationship of patient to the Insured _____________ Relationship of patient to the Insured _______________

The following information is requested by the U.S. government:

Race: ☐White ☐Black/African American ☐Asian ☐Other ☐Decline to Answer/Unknown

Ethnicity: ☐Spanish/Hispanic ☐Not Spanish/Hispanic ☐Decline to Answer/Unknown

Languages Spoken: ☐English ☐Spanish ☐Other _________________________

Assignment and Release: I hereby authorize the release of any medical information necessary to process this claim, and request payment of medical benefits to be made directly to the physician. I understand that my healthcare insurance company may require me or my primary care physician to obtain pre-authorization and/or referral for a procedure performed by this office. I am aware that referrals and authorizations, if necessary, are my responsibility and must be obtained prior to my visit.

Please be advised that we are unable to change or alter the facts for you to obtain coverage for your office visit.

Patient or Responsible Party Signature ___________________________________ Date _____/_____/_______

JEFFREY L. AINSPAN, M.D. PC

OFFICE FINANCIAL POLICY

We would like to share the following policy with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

If we participate with your insurance, you are responsible for all copays, co-insurance, and deductibles under your plan. You are solely responsible for all non-covered and cosmetic services provided. Copays, and payments for cosmetic or uncovered services known on date of service are required at time of service. You will be billed for any deductibles, co-insurance, and any services later deemed uncovered by your insurance company based upon your specific policy coverage. Payment is due 30 days after statement date. Please be aware that any in-office procedure is billed separately from your office visit. If a biopsy is sent to pathology, you are responsible for any portion of the laboratory service fee if it is not covered by your insurance. **WE DO NOT PARTICIAPTE WITH OR ACCEPT STRAIGHT MEDICAID**, only specific Medicaid HMOs.

If you are covered by Medicare and a service is to be provided which may not be covered by Medicare, prior to providing this service, you will be asked to sign a Waiver of Liability Form (Advance Beneficiary Notice). If Medicare subsequently denies coverage for this service, you will be responsible for payment.

If your insurance carrier requires a referral, you are required to provide this office with the referral from your primary care physician. If you cannot obtain your referral prior to your visit, please reschedule your appointment. Please make sure to give the office a minimum of 24 hours notice. If you wish to be seen without the required referral, you are responsible for payment, as your insurance carrier will deny coverage.

You are personally financially responsible for charges incurred for services rendered by this office if any of the following apply:

1) You are not a member of a plan or you have chosen not to use your health plan.
2) Your health plan coverage has expired or lapsed at time of service (this includes retroactive termination)
3) Your health plan has denied coverage because it has not received coordination of benefit or pre-existing information from you.
4) Your health plan does not reimburse us for the services provided because they do not consider the service medically necessary.
5) Our office does not participate with your health plan.

We will bill your primary insurance carrier if we participate with them. If your primary carrier denies payment due to your not being covered at time of service, or denies payment due to lack of coordination of benefit information or lack of other information from you (i.e. lack of proof of student status), you will be billed and will be responsible for the entire amount. If we receive payment from your primary insurer, we will file a claim with your secondary insurer, if you have one. If we do not receive payment from your secondary carrier, you will be billed for the remaining amount indicated by your primary insurer as patient responsibility.

If we do not participate in your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. Payment for services is expected at time of service. We will provide you with a receipt that you can submit to your insurance carrier for reimbursement.

If you have to cancel or reschedule your appointment, our office requires a minimum of 24 business hours notice prior to the time of your appointment. If your appointment is on Monday or on the day following a holiday, notification must take place on the prior business day, prior to the time of your appointment, in order for us to have 24 business hours notice.

The following is a summary of fees charged by our office:

- A fee of $10.00 will be charged for any co-pay not paid at the time of service.
- A fee of $75.00 will be charged for no-shows or same day cancellations. We must be notified at least 24 hours prior to your appointment on the previous business day. For appointments scheduled on a Monday or the day after a holiday, we must be notified by 1PM on the previous business day.
- If an extended appointment is scheduled (30 minutes or more) a fee of $100 will be charged for no-shows, same day cancellations and reschedules with less than 24 hours notice.
- A fee of $100.00 will be charged if a patch test scheduled for Monday is cancelled after 1PM on the previous Friday.
- A fee of $30.00 will be charged for any returned check.
- In the event that your account must be turned over to collections, you agree to reimburse us the fees of any collections agency, based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office. This policy is subject to any contrary provisions of law or provisions of our contract with your health plan, if applicable.

____ Patient Signature

____________________ Date

JEFFREY AINSPAN, M.D. PC

308A EAST 15th STREET

NEW YORK, NEW YORK 10003

TELEPHONE (212) 505-5790

Receipt of Notice of Privacy Practices - Acknowledgement and Consent

By signing below:

1. I acknowledge that I have been provided with a copy of the Notice of Privacy Practices from the practice of Jeffrey Ainspan, M.D. PC (the Practice) , and have therefore been advised of how my health information may be used and disclosed by this office, and how I may obtain access to and control this information.
2. I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this office. Other than the reasons just listed, I will allow the Practice to also discuss my medical information with the following individual(s):

Contact	Relationship	Phone	Cell Phone
______________ ______________	______________	______________	______________
______________ ______________	______________	______________	______________
______________ ______________	______________	______________	______________
______________ ______________	______________	______________	______________

3. Other than specifically restricted below, I will allow the Practice to leave voice messages regarding my appointments on my home phone, my cell phone, or my office voice mail. Appointment information may also be sent via text message to my cell phone, to my email, or mailed to my home. I will allow appointment information to be given to anyone answering my home phone, cell phone, or work phone. I request that the following restrictions be used when communicating my appointment information:

   ____.

   I understand that the Practice may not be able to comply with this request.

4. I authorize the Practice to download my medication history from Sure Scripts. Other than specifically restricted below, the Practice will NOT leave any medical information on any of my phone answering devices. The Practice can leave a message to call the Practice on my home phone, my cell phone, or my personal office voice mail. .

   I request the following restrictions be used when communicating my medical information:

   ____

5. I authorize Dr. Ainspan to be my Authorized Representative for the purpose of appealing the denial of benefits for any claim submitted by this office on my behalf to my insurance carrier.

____________________________________ ________________
Signature of Patient or Personal Representative Date

____
Print Name of Patient

__________________________________ _____________________________________
Print Name of Personal Representative Description of Personal Rep.'s Authority

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MEDICAL HISTORY

Patient Name ______________________________ DOB: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: ____

____

Past/Current Medical History: (Please circle all that apply) ☐ NONE

	Past	Current		Past	Current
Anxiety	☐	☐	Hearing Loss	☐	☐
Arthritis	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Hypertension	☐	☐
Atrial fibrillation (Irreg. Heartbeat)	☐	☐	HIV/AIDS	☐	☐
Bipolar Disorder	☐	☐	Hypercholesterolemia	☐	☐
Bone Marrow Transplantation	☐	☐	Hyperthyroidism	☐	☐
BPH (Benign Prostatic Hyperplasia)	☐	☐	Hypothyroidism	☐	☐
Breast Cancer	☐	☐	IBD (Irritable Bowel Disease)	☐	☐
Colon Cancer	☐	☐	Leukemia	☐	☐
COPD	☐	☐	Lung Cancer	☐	☐
Coronary Artery Disease	☐	☐	Lymphoma	☐	☐
Crohn's Disease	☐	☐	Polycystic Ovaries	☐	☐
Depression	☐	☐	Prostate Cancer	☐	☐
Diabetes	☐	☐	Radiation Treatment	☐	☐
Emphysema	☐	☐	Seizures	☐	☐
Endometriosis	☐	☐	Stroke	☐	☐
End Stage Renal Disease	☐	☐	Tuberculosis	☐	☐
GERD	☐	☐	Uterine Fibroids	☐	☐
Glaucoma	☐	☐			
Graft-versus-host Disease	☐	☐			

Other ____

MEDICAL HISTORY

Patient Name ________________________________ DOB: ___/___/___ Today's Date: ___/___/___

Past Surgical History: (Please circle all that apply) ☐ NONE

Appendix Removed		Liver Hepatectomy	
Bladder Removed		Liver Transplant	
Breast Biopsy		Liver Shunt	
Lumpectomy (Right, Left, Bilateral)		Ovaries Removed: Endometriosis	
Mastectomy (Right, Left, Bilateral)		Ovaries Removed: Ovarian Cancer	
Breast Reduction		Ovaries Removed: Ovarian Cyst	
Breast Implants		Ovaries Tubal Ligation	
Colectomy: Colon Cancer Resection		Pancreas Pancreatectomy	
Colectomy: Diverticulitis		Prostate Biopsy	
Colectomy: IBD		Prostate Removed: Prostate Cancer	
Colon: Colostomy		Prostate: TURP (Transurethral resection)	
Gallbladder Removed (Cholecystectomy)		Rectum APR	
Heart: Biological Valve Replacement		Rectum Low Anterior Resection	
Heart: Coronary Artery Bypass		Skin Basal Cell Carcinoma	
Heart Transplant		Skin Melanoma	
Heart: Mechanical Valve Replacement		Skin Biopsy	
PTCA (Coronary angioplasty)		Skin Squamous Cell Carcinoma	
Joint Replacement-Hip (Right, Left, Bilateral)		Spine surgery	
Joint Replacement-Knee (Right, Left, Bilateral)		Spleen Removed	
Joint Replacement within last 2 years		Testicles Removed (Right, Left, Bilateral)	
Kidney Biopsy		Hysterectomy: Fibroids	
Kidney Stone Removed		Hysterectomy: Uterine Cancer	
Kidney Transplant		Hysterectomy: Cervical Cancer	
Kidney Removed (Nephrectomy) (Right, Left)			

Other ____

Patient Name ________________________________ DOB: ___/___/___ Today's Date: ___/___/___

Skin Disease History: (Please circle all that apply) ☐ NONE

Acne	Herpes
Actinic Keratosis	Lupus
Asthma	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Psoriasis
Eczema	Shingles
Flaking or Itchy Scalp	Skin Cancer - Basal Cell
Grover's Disease	Skin Cancer - Melanoma
Hair Loss	Skin Cancer - Squamous Cell
Hay Fever/ Allergies	

Other ____

Do you wear Sunscreen: ☐Yes ☐No If yes, what SPF?__________
Do you tan in a tanning salon: ☐Yes ☐No

Past Family History: Check following medical conditions that have occurred in your family: ☐ NONE

Disease	Mother	Father	Blood Relative -indicate which relative(s)
Allergies	☐	☐	☐ ________________
Arthritis	☐	☐	☐ ________________
Asthma	☐	☐	☐ ________________
Cancer	☐	☐	☐ ________________
Diabetes	☐	☐	☐ ________________
Eczema	☐	☐	☐ ________________
Hair Loss	☐	☐	☐ ________________
Heart Disease	☐	☐	☐ ________________
High Blood Pressure	☐	☐	☐ ________________
Lung Disease	☐	☐	☐ ________________
Malignant Melanoma	☐	☐	☐ ________________
Psoriasis	☐	☐	☐ ________________
Skin Cancer	☐	☐	☐ ________________

Other ____

Medications: (Enter ALL current Rx medications, over-the-counter medications, as well as all vitamins, minerals and supplements) ☐ NONE

MEDICATION	DOSAGE	FREQUENCY	ROUTE (i.e. ORAL, etc.)

Allergies: (Please enter ALL allergies) ☐ NONE

____
____
____

Patient Name ________________________________ DOB: ___/___/___ Today's Date: ___/___/___

Social History:
Occupation:__________________________ Hobbies/Leisure activities:_____________________

Do you smoke? ☐ Never ☐ Quit: Former Smoker ☐ Smoke less than daily ☐ Smoke daily
Do you drink alcohol? ☐ Never ☐ Less than 1 drink/day ☐ 1-2 drinks/day ☐ 3 or more drinks/day

Women: Birth Control? ☐Yes ☐ No Planned pregnancy? ☐Yes ☐ No Pregnant? ☐Yes ☐ No

Alerts: Are you currently experiencing any of the following? (Please check yes or no) ☐ NONE

	Yes	No
Allergy to adhesive	☐	☐
Allergy to lidocaine	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Allergy to latex	☐	☐
Artificial heart valve	☐	☐
Artificial joints within past 2 years	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
Bacterial Infection/ MRSA	☐	☐
Pacemaker	☐	☐
Premedication needed prior to procedures	☐	☐
Rapid heartbeat with epinephrine	☐	☐

Review of Systems: Are you currently experiencing any of the following? ☐ NONE
(Please check yes or no)

	Yes	No		Yes	No
Problems with bleeding	☐	☐	Blurry vision	☐	☐
Problems with healing	☐	☐	Abdominal pain	☐	☐
Problems with scarring	☐	☐	Jaundice	☐	☐
Rash	☐	☐	Joint Aches	☐	☐
Photosensitivity	☐	☐	Muscle weakness	☐	☐
Immunosuppression	☐	☐	Joint aches	☐	☐
Hay fever	☐	☐	Neck stiffness	☐	☐
Frequent infections	☐	☐			
Chest pain	☐	☐	Headaches	☐	☐
Irregular heart beat	☐	☐	Seizures	☐	☐
Fainting	☐	☐	Loss of sensation	☐	☐
Fever or chills	☐	☐	Sore throat	☐	☐
Night sweats	☐	☐	Cough	☐	☐
Unintentional weight gain/loss	☐	☐	Shortness of breath	☐	☐
Thyroid problems	☐	☐	Wheezing	☐	☐
Hair loss	☐	☐	Anxiety	☐	☐
Menstrual irregularities	☐	☐	Depression	☐	☐

Other ____

____

Reviewed________________________________ Date: ___________ Update Date: _________________
MD Signature

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