ANDREW H. KRINSKY, MD., LLC New/Update PATIENT FORM

(Please Print Clearly)

PATIENT NAME:_____ **DATE:**_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SS#: _____ **DOB:** _____ **SEX (circle one): M F**

HOME PHONE: _____ **CELL:** _____
(please circle your preferred phone #)

EMAIL ADDRESS:_____

MARITAL STATUS (circle one): S M W D REFERRED BY: _____

EMPLOYER: _____

ADDRESS: _____ **PHONE:** _____

SPOUSE: _____

SPOUSE EMPLOYER: _____

ADDRESS: _____ **PHONE** _____

PRIMARY LANGUAGE SPOKEN:_____ **DO YOU NEED A TRANSLATOR?: YES___ NO___**

IN CASE OF EMERGENCY: _____ **PHONE:**_____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU: _____

PHONE: _____

PHARMACY NUMBER: _____

IF OVER 18, DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?: YES_____ NO_____

IF NO, WOULD YOU LIKE INFORMATION CONCERNING YOUR RIGHTS REGARDING ADVANCE DIRECTIVES?: YES_____ NO_____

INSURANCE:_____ **ID #:**_____

GROUP #:_____ **PHONE:**_____

INSURANCE POLICY HOLDER: _____

POLICY HOLDER SS: _____ **DOB:** _____

RELATIONSHIP: _____**PHONE:** _____

7-2-20-20

Notice of Malpractice Insurance, No Show Appointments & Assignment of Benefits

A: I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Andrew H. Krinsky LLC, Inc.

B: **I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said Assignor to release all information necessary to secure payment.**

C: **I understand it is my responsibility to know what my insurance coverage is, if I am responsible for any deductible, co-ins or copay.**

D: **EVEN THOUGH WE MAY HAVE CONTACTED YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE, IT IS NOT A GUARANTEE OF PAYMENT.**

E: Payments **MUST** be made at the time of each visit, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I understand Andrew H. Krinsky LLC, Inc. reserves the right to charge an administrative fee of $15.00 for any deductible, co-ins or copay not paid at the time of service. A surcharge of 35% will be added to any accounts sent to our collection department.

F: We confirm appointments as a courtesy, it is your responsibility to be aware of the date and time.

G: I understand that I will be charged a $25.00 fee for any no show appointments or cancellations without 24 hour prior notice.

H: I understand that as of 03/01/05 Dr Krinsky does not carry medical malpractice insurance.

I. Dr. Krinsky's practice primarily consists of office gynecology and minor outpatient surgery. Should you need hospitalization or major surgery Dr. Krinsky will provide you with an appropriate referral.

J. If you are going to be more the 10 minutes late for your appointment, we ask that you make a courtesy call informing the office. If you are more then 20 minutes late for your appointment depending on how the schedule is running, you may be asked to reschedule your appointment.

K. I understand that it may be necessary for Dr. Krinsky to perform certain lab tests during my visit that may not be covered by my insurance company. In that event I understand I will be responsible for the charge upon check-out.

L. **I consent to a medically indicated exam including but not limited to a Pelvic & Rectal Exam.**

I HAVE READ AND UNDERSTAND THE ABOVE

Signed by: _____ DATE: _____

I hereby authorize my medical information and/or results to be discussed with anyone listed below.

Signed by: _____ DATE: _____