**STUART D. KATCHIS, M.D., P.C.**
**Orthopaedic Surgery**

**Patient Information** **(Please PRINT CLEARLY and COMPLETELY)** Date _____

Last Name _____ First Name _____ Middle Name _____

Parent / guardian (if applicable) _____

Address _____ Apt #:_____ Telephone (home) _____
City, State_____ (work) _____
Zip code _____ (mobile) _____
Email Address_____ (fax) _____

Age _____ Occupation _____
Date of Birth _____ Employer _____
Social Security # _____ Referring Dr _____ Ph #_____
Marital Status _____ Primary Dr _____Ph# _____

Emergency Contact _____ Phone # _____

**Medical Information**

Current Problem – Left / Right: _____
_____
_____

How did it occur? _____
_____
_____

Duration of symptoms _____ Filing for No-Fault / Worker's Compensation? _____

Current and Past Medical Problems (please check those that apply):

- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Pacemaker
- ❑ Diabetes
- ❑ Lung Problem
- ❑ Smoker
- ❑ Asthma
- ❑ Stroke
- ❑ Neuropathy
- ❑ Stomach Ulcer
- ❑ Intestinal Problems
- ❑ Rheumatoid Arthritis
- ❑ Hypertension
- ❑ Sleep Apnea
- ❑ Other (please list): _____ _____
  _____ _____
  _____ _____

Past Surgeries (please list): ☐ Check box if none _____
_____ _____
_____ _____

Current Medications (please list): ☐ Check box if none _____
_____ _____ _____
_____ _____ _____

Allergies (please list): ☐ Check box if none _____ _____

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**Insurance Information** (Please have cards available)

**(No-Fault / Worker's Comp – Please ask for different form)**

Primary Insurance

Company _____ Claims Address_____

ID# _____ _____

Group# _____

Policy Holders' Name _____ Relationship to Patient _____

Policy Holders' Date of Birth _____ Policy Holders' Employer _____

Secondary Insurance

Company _____ Claims Address _____

ID# _____ _____

Group# _____

Policy Holders' Name _____

Policy Holders' Date of Birth_____ Policy Holders' Employer _____

**Claims Authorization for All Patients**

I hereby authorize any physician, health care practitioner, hospital, clinic or other medical facility to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s).

I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer or an insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

**Additional Authorization for Medicare Policyholders**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

**Assignment of Benefits**

I authorize payments of medical and surgical benefits to be made on my behalf to my physician(s) in this office. I also understand I am fully responsible for this bill if the insurance co. either denies or neglects the amount due.

**Patient/Relative/Guardian** Signature: _____

Print Name: _____

Date: _____ Relationship to Patient: _____

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## NON PARTICIPATING / OUT OF NETWORK AGREEMENT

I _____ have been notified that Stuart D. Katchis, M.D. is not an in network / participating provider with _____.

I understand that because he is not an in network / participating provider with this insurance that I will be responsible for all consult payments, including the annual deductibles, co-pays and co-insurance of this and all follow-up & surgery visits included.

Patient Signature: _____ Date: _____

Affiliated with Lenox Hill Hospital & Surgicare of Manhattan as an out of network physician except medicare, no-fault & worker's compensation
Primary out of network initial consult ($350), follow-up visit ($200-$250), casting ($350), injection ($460), xrays ($125-$250), dme ($2-$120)

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

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### *OFFICE USE ONLY*

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason:_____