ITHACAMED 404 North Cayuga Street Ithaca, New York 14850 www.ithacamed.com

Patient's Last Name: ________________________ First: ________________________ MI: ____

Address: ________________________ Apt#:__________ City: ________________________

State: ______________ ZIP: ____ ____ ____ ____ ____ Gender: Male______ Female______ Marital Status: _________

Date of Birth: ______/______/_______ Social Security Number: ____ ____ ____-____ ____-____ ____ ____ ____

Home Phone#: ( ) ________________________ Cell Phone#: ( ) ________________________

If you consent to using e-mail to communicate with our office, please enter your e-mail address below:

Email Address: ________________________

Patient's employer: ________________________ Work Phone#: ( ) ________________________

If a student, school/college: ________________________ City: ________________________ State: _______

Spouse or partner's name: ________________________ Phone#: ( ) ________________________

Person to contact in case of an emergency: ________________________ Relationship: ________________________

Address: ________________________ Phone#: _________________Work/Cell#:________________

Referring source (circle one): physician friend former patient yellow page newspaper Internet other

If this visit is a referral from another doctor please fill out this section:

Referring Doctor: ________________________ Address: ________________________

Telephone#: ( ) ________________________ Primary Care Physician: ________________________

IS THIS A WORKERS COMP OR NO FAULT CLAIM: YES NO If yes, please see the receptionist for additional paper work

Primary Insurance Company: ________________________

Policy Holders Name: ________________________ Relationship to Pt.: Self__ Spouse__ Parent__ Other_______

Addresses (If different from patient): ________________________City: ________________

State: _________ Zip Code: ____ ____ ____ ____ ____

DOB: _____/_____/______ Social Security Number: ____ ____ ____-____ ____-____ ____ ____ ____

Policy Number: ________________________ Group Number: ______________________ Co-pay:________

*****We must have policy holders Date of birth and Social Security number or the insurance company will reject the claim and you will be held responsible for the bill*****

Secondary Insurance Company: ________________________

Policy Holders Name: ________________________ Relationship to Pt.: Self__ Spouse __ Parent__ Other________

Addresses (If different from patient): ________________________City: ________________

State: _________ Zip Code: ____ ____ ____ ____ ____

DOB: _____/_____/______ Social Security Number: ____ ____ ____-____ ____-____ ____ ____ ____

Policy Number: ________________________ Group Number: ______________________ Co-pay:_______

I have agreed to allow certain individuals participate in discussion and decisions related to my care. Therefore, I hereby give my permission to Dr. Adam Law and his staff to disclose my personal medical and financial information to the following individual(s) named: ________________________. This includes account information, making of appointments, canceling appointments, prescription concerns and etc.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. IthacaMed reserves the right to charge for any appointments missed or not canceled without 24 hours notice. I have read the information on this form and have completed the above answers and certify that the information is true and correct to the best of my knowledge. It is my responsibility as the patient to request a referral if required by my insurance company and to notify the office of any change of address, telephone number or insurance.

Signature: ________________________ Date: ________________________

IthacaMed
404 North Cayuga Street Ithaca NY 14850
P. 607-277-0969 F. 607-277-3242

IthacaMed Financial Policy

PATIENT FINANCIAL RESPONSIBILITY: IthacaMed will provide medical services and in turn you as the patient will be held liable for the portion of the cost of medical care for which you are responsible. IthacaMed will make every effort to work with you to resolve your financial obligation to this facility in the event that you have experienced a financial hardship. Some services may not be covered by your plan. In the event that your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. We will not change coding on the bill for benefit of reimbursement by your insurance company. Please make yourself familiar with your plan.

MEDICARE: IthacaMed is a provider for the Medicare program. The patient is responsible for payment of co-payment and deductibles of covered services and the full amount of any service that is not covered.

INSURANCE/THIRD PARTY PAYORS: IthacaMed will assist the patients in making every effort to collect payments from the patients or the guarantors insurance company through courtesy filing of insurance claims and other required documentation. Since most carriers have time limits on filing correct information on the claims, it is imperative that we receive complete and correct insurance information. We ask that you bring your card with you to every office visit. Though assistance will be provided by our billing office, it is the patient's responsibility to make sure his/her insurance carrier pays his/her claims. Patients or the guarantor are responsible for payment in full of their financial obligations whether or not their insurance makes a payment. Co-pay's are due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept Visa, Master Card, and Discover, personal checks, money orders and cash. If your co-pay is not paid at the time of service $15 charge will be added to your bill.

NON PARTICIPATING PLANS: If you are insured by a plan that we do not have an arrangement with or participate with, we will prepare and send the claim for you as a courtesy. This means the insurer will send payment directly to you. Therefore, our charges for your care are due at the time of service. If you cannot pay the full amount we do require a 50% down payment and you may discuss a payment plan with the office manager.

SELF-PAY and/or OBLIGATION DUE AFTER 3rd PARTY PAYMENT: Patients who have no other source of payment of services as noted above or who have an account balance due after payment from another source are responsible for the payment of their account in full within 30 days. Failure to satisfy a patient's financial obligations may require IthacaMed to transfer your account to a collection agency and may impact your credit rating. In the event that your account is transferred to a collection agency you will be responsible for all cost including court cost, collection fees and up to 20% attorney fees.

HOSPITAL/OUTSIDE CHARGES: IthacaMed will bill your insurance plan for any visit that we provide while you are admitted. Charges for services by the laboratory, pathology, or hospital or other health care professionals not employed by IthacaMed will not be a part of your bill from IthacaMed. You will be billed separately for additional services.

MISSED/CANCELED APPOINTMENTS: Missed or canceled appointments without giving us 24 hours notice causes unnecessary expense and increased overhead for our office. If you cannot make your appointment please notify us 24 hours in advance. You may leave us a message over the weekend or with the answering service. We call to remind you of your appointment two days in advance and also send out email reminders. You will be charged $40.00 if the appointment is missed/not canceled without 24 hours notice and we have not been successful at filling the slot with another appointment.

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. It is your responsibility as the patient to familiarize yourself with your specific insurance plan. If you are in need of an insurance referral you will need to contact our office before services are rendered. If a referral is not completed before rendered service it is your responsibility for balance due.

I have read and understand the IthacaMed's financial policy and I agree to be bound by its terms.

Signature: ____

Print Name: ____

Date: ____________________

ITHACAMED 404 North Cayuga Street, Ithaca, New York 14850 •

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Dr. Law for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of IthacaMed. I understand that diagnosis or treatment of me by Dr. Law may be conditioned upon my consent as evidenced by my signature on this document.
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Law is not required to agree to the restrictions that I may request. However, if Dr. Law agrees to a restriction that I request, the restriction is binding on Dr. Law. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Law has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review IthacaMed's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of IthacaMed. The Notice of Privacy Practices for IthacaMed is also provided at 404 North Cayuga Street in Ithaca and on IthacaMed's website at *www.ithacamed.com*. The accompanying Notice of Privacy Practices also describes my rights and Dr. Law's duties with respect to my protected health information. Dr. Law reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing IthacaMed's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
PRINT Name of Patient

____
Description of Personal Representative's Authority if applicable

____
Date