HOSPITAL FOR SPECIAL SURGERY

Alice Chen, MD/IP CT, LLC.
Hospital for Special Surgery
1 Blachley Rd~Stamford, CT 06902
(203) 705-2087-Office (877)-363-0849-Fax

Date: ______________
MR#:_______________

REGISTRATION FORM

PATIENT INFORMATION

Name:____ I Prefer to be called: ____________________________

Address:____City:________________State:_________Zip________________

Phone (_______)__________________ Work Phone (_____) ________________ Cell Phone (______)____________________

Date of Birth:________________ Social Security Number:______________________ Sex:_________ Race:______________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced How did you hear of us?__________________

Email Address____

Primary Care Physician:______________________________ Phone #: __________________ Fax#:______________________

Referring Physician:____ Phone#: __________________ Fax#:_________________

If Student, Name of School________________________________ City/State_____________________________ ☐ FT ☐ PT

Employer____ Occupation_____________________ ☐ FT ☐ PT ☐ Retired

Employer Address ____ Employer Phone____________________

Emergency Contact: _________________________ Relationship: ______________________Phone_______________________

GUARANTOR

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____ Relationship to Patient: _______________________

Address:____

City:___________________________________ State:__________ Zip:_____________ Phone: (____)______________________

Employer___________________________ Work Phone (____) __________________ SSN#______________________________

INSURANCE INFORMATION

Name of Insured___________________________________DOB_______________Relationship to Patient _________________

SSN#:_________________________ Name of Employer:________________________ Work Phone: (____)_______________

Address of Employer:_____________________________________City__________________State:________Zip ____________

Insurance Company______________________________ Grp #_______________________ ID#__________________________

Ins Co Address:____ Ins Co. Phone:______________________________

-- SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ☐ WORKER'S COMP ☐ MEDICAID ----

Name of Insured___________________________________DOB_______________Relationship to Patient _________________

SSN#:_________________________ Name of Employer:________________________ Work Phone: (____)_______________

Address of Employer:_____________________________________City__________________State:________Zip ____________

Insurance Company______________________________ Grp #_______________________ ID#__________________________

Ins Co Address: ____ Ins Co. Phone: _____________________________

Office Use Only

Height:__________ **Weight:**__________ **BP:**___________ **HR:**___________ **Temp:**___________ **Initials:**________

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PATIENT FINANCIAL POLICY & CONSENT FOR RELEASE OF INFORMATION

I hereby authorize payment of medical benefits billed to my insurance company. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Physician does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

I, _________________________________, hereby authorize **ALICE CHEN, MD/IP CT, LLC.** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **ALICE CHEN, MD/IP CT, LLC** can refuse to treat me.

I have been informed that **ALICE CHEN, MD/IP CT, LLC.** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **ALICE CHEN, MD/IP CT, LLC.** in writing, but if I revoke my consent, such revocation will not affect any actions that **ALICE CHEN, MD/IP CT, LLC.** took before receiving my revocation.

I understand that **ALICE CHEN, MD/IP CT, LLC.** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **ALICE CHEN, MD/IP CT, LLC.** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **ALICE CHEN, MD/IP CT, LLC.** does not have to agree to such restrictions, but that one such restrictions are agreed to, must adhere to such restrictions.

____ ________________

Signature of patient or patient's representative Date

(Form MUST be completed before signing.)

____

Printed name of patient or patient's representative

____

Relationship to the patient