Steven Batash MD

Gastroenterology & Bariatric Endoscopy
97-12 63rd Drive Rego Park, NY 11374
Tel: (718)830-0004 Fax: (718)261-4420
www.batashmedical.com

PATIENT INFORMATION

Date (fecha)**:** _____

Language Preference (preferencia de idioma)**:** ☐**English** ☐**Spanish** ☐**Russian** ☐ **Other** _____

Patient First Name (Primer nombre del paciente)**:** _____

Last Name (apellido)**:** _____

Gender: ☐ F ☐ M **Marital Status** (Estado civil)**:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (Fecha de nacimiento)**:** _____/_____/_____ **SSN#:** (Seguridad Social**#**): _____-_____-_____

Address (dirección): _____ **Apt#:** _____

City (Ciudad)**:** _____ **State** (Estatdo)**:** _____ **Zip Code** (Código postal)**:** _____

Phone (número de teléfono) **Home:** _____ **Cell:** _____ **Work:** _____

Email (correo electrónico): _____ **Occupation** (empleo)**:** _____

Employer Name (Nombre del empledor): _____**Phone**(Número):_____

City (Ciudad)**:** _____ **State** (Estatdo)**:** _____ **Zip Code** (Código postal)**:**

Emergency Contact (contacto de emergencia)**:**

Name (nombre): _____**Relation**(relación): _____ **Number**(Número): _____

Insurance Information

(Información del seguro)

Primary Insurance (Seguro primario)

Insurance Name (Nombre del Seguro): _____ **ID:** _____

Name of Subscriber (Nombre del Suscriptor) : _____ **SSN#:** _____-_____-_____

Subscribers Date of Birth (Fecha de nacimiento del suscriptor): ____/_____/_____

Patients relationship to Subscriber (Relación con el suscriptor): ☐**Self** ☐**Spouse** ☐**Child** ☐**Other**

Secondary Insurance (Seguro primario)

Insurance Name (Nombre del Seguro): _____ **ID:** _____

Primary Care Doctor

Name: (Nombre del médico de atención primaria) _____

Office Phone (número de oficina)**:** _____

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PATIENT INFORMATION

Medical History: (List all current and past medical history)
Historial médico**:** (Anote todo el historial médico actual y pasado)

_____
_____
_____
_____

Are you taking any medications: ☐ Yes ☐ No If yes, please list name and reason for use below:
Estas tomando alguna medicación: (Por favor, indique el nombre y la razón de su uso a continuación):

_____
_____
_____
_____

Are you allergic to any medications: ☐ Yes ☐ No If yes, please list name below:
¿Es alérgico a algún medicamento? (Si la respuesta es sí, por favor escriba el nombre abajo):

_____
_____
_____

Pharmacy Information

Pharmacy Name (Nombre de la farmacia)**:** _____

Phone Number (número de teléfono)**:** _____

Address(dirección): _____

City(Ciudad)**:** _____ **State** (Estatdo)**:** _____ **Zip Code** (codigo postal)**:** _____

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PATIENT INFORMATION

Name: _____ **Date of Birth: _____/_____/_____**

SS# / ID: _____ **Phone #: _____**

AUTHORIZATION TO RELEASE AND OBTAIN
HEALTH INFORMATION PURSUANT TO HIPPA LAW 1996

I, or my authorized representative, authorize _____ to release my protected health information as set forth on this form and in accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability act of 1996.

I have the right to limit which types of records can be obtained

- ☐ All medical records
- ☐ Parts of my medical records as described below: _____

_____

I have the right to limit which types of records can be released as described below

- ☐ Authorization to release is limited to: _____

I have the right to request that part of my protected health information not be disclosed to family members or friends who may be involved in my medical care as described below

- ☐ I request my information not be disclosed to:_____

I have the right to limit this authorization

- ☐ Specifically limit this authorization only to the person/provider Faculty or institution indicated: _____

I, or my authorized representative, authorize Dr. Steven Batash MD to obtain health information regarding my care and treatment from my primary care physician or any other healthcare provider or facility involved in my care for treatment, consultation or other purpose set forth on this form and in accordance with the Privacy Rule.
Purpose of authorization,

- ☐ Medical care/ treatment/consultation
- ☐ Other: _____

I have the right to limit this authorization to obtain protected health information to a certain provider/facility/ institution

- ☐ Authorization is limited to _____ _____
  Name of provider Telephone number

If I authorize the release of HIV related information, Dr. Steven Batash is prohibited from re disclosing such information without my consent unless permitted to do so under federal or state law. I also have the right to request a list of people who may receive or use my HIV related information without authorization.
I have the right to revoke the authorization to release and/or obtain my protected health information at any time by putting it in writing and submitting it to Dr. Steven Batash. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that signing this authorization is voluntary and my treatment will not be conditioned on whether I sign this authorization.
I release Dr. Steven Batash from all legal responsibility or liability that may arise from authorized release of information.
If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations my information will not be protected by the New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act. However, my protected health information will not be re disclosed without my permission unless directed by NYS or Federal Law.
I understand I may request a copy of my medical records. There may be a reasonable fee for copying records over 25 months old.

X_____ Relation to patient: _____ Date_____
Signature of Patient (If minor, Parent/Guardian Signature)

☐ I have received a copy of HIPPA Privacy Notice and policy and understand that I can speak to HIPPA compliance officer if I have any further questions.

X_____ Relation to patient: _____ Date_____
Signature of Patient (If minor, Parent/Guardian Signature)_

For Internal Use:

☐ Patient refused to sign ☐ Patient unable to sign for the following reason: _____

_

Financial Policy and Benefits Assignment

Financial Policy:

We will be happy to submit medical claims to most insurance carriers if you provide us with your policy, address, and copy of the insurance card. You are responsible for all deductibles, copayments and coinsurance payments. Prompt payment for balance due is expected. Delinquent accounts which have to be turned over to a Credit Reporting Collection Agency will have their balances increased 30% to cover the expenses associated with the Collection Agency. In addition to these expenses, delinquent accounts are also liable for Attorney fees and court costs associated with the collection of the debt.
(Estaremos encantados de presentar reclamaciones médicas a la mayoría de las compañías de seguros si nos proporciona su póliza, dirección y copia de la tarjeta de seguro. Usted es responsable de todos los deducibles, copagos y coaseguros. Se espera un pronto pago por el saldo pendiente. Las cuentas en mora que tienen que ser entregadas a una agencia de cobro de informes de crédito tendrán sus saldos aumentados un 30% para cubrir los gastos asociados con la Agencia de Cobros. Además de estos gastos, las cuentas morosas también son responsables de los honorarios del abogado y los costos judiciales asociados con la recaudación de la deuda).

Assignment of Benefits:

I assign any rights I may have under my insurance agreement to Dr. Batash to recover any medical expense benefits due to me. In the event that my insurance company denies payment I authorize Dr. Batash to appeal on my behalf. I authorize my insurance company to pay my medical expense benefits directly to: (Yo asigno cualquier derecho que pueda tener bajo mi contrato de seguro al Dr. Batash para recuperar cualquier beneficio de gastos médicos que se me debe. En caso de que mi compañía de seguros niegue el pago autorizo al Dr. Batash a apelar en mi nombre.Autorizo a mi compañía de seguros a pagar mis beneficios de gastos médicos directamente a):

Steven Batash, MD
9712 63rd Drive
Rego Park, NY 11374

I have read the above Financial Policy and Assignment of Medical Benefits and accept responsibility for this account. I authorize the use of this signature for all insurance submissions. (He leído la anterior Política Financiera y Asignación de Beneficios Médicos y acepto la responsabilidad de esta cuenta. Autorizo el uso de esta firma para todas las presentaciones de seguros.)

X_____ Relation to patient: _____ Date_____
Signature of Patient (If minor, Parent/Guardian Signature)

Office Policies

1. **We provide services without regard to sex, race, religion, national origin or disability.** (Ofrecemos servicios sin consideración de sexo, raza, religión, origen nacional o discapacidad.)
2. **We don't honor DO NOT Resuscitate Directives and/or Living Wills (Resuscitation is a medical procedure which seeks to restore cardiac and/or respiratory function to individuals who have sustained a cardiac and/or respiratory arrest. "Do Not Resuscitate" ("DNR") is a medical order to provide no resuscitation to individuals for whom resuscitation is not warranted.)** En medicina, un "no resucitar" o "DNR", a veces llamado un "No Code", es una orden legal escrita, ya sea en el hospital o en una forma legal de respetar los deseos de un paciente a no tener CPR o cardíaca avanzada soporte de vida (ACLS) si su corazón se detuviera o si usted deja de respirar. (RESUCITAR es un procedimiento médico que busca restaurarla función cardiaca y/ o respiratoria a las personas que han sufrido una parada cardiaca y /o respiratoria y el DNR es para personas que no desean esos servicios. NOSOTROS NO HONRAMOS DNR (DO NOT RESUSCITATE POLICY)
3. **We provide you with a copy of the Patient Bill of Rights and responsibilities.** (Le proporcionamos una copia de la Carta de Derechos y Responsabilidades del Paciente)
4. **We encourage you to actively participate in your care.** (Le animamos a participar activamente en su cuidado).
5. **The following information is readily available to you: information regarding the ownership of the practice, the expertise of the associated physicians, the patient grievance process and safety inspection control practices.** (La siguiente información está disponible para usted: información sobre la propiedad de la práctica, la experiencia de los médicos asociados, el proceso de quejas del paciente y las prácticas de control de inspección de seguridad.)

I have reviewed and understand Office Policies: (He revisado y entendido las Políticas de la Oficina):

X_____ Relation to patient: _____ Date_____
Signature of Patient (If minor, Parent/Guardian Signature)

We accept all major credit cards and **CareCredit**. We also offer no interest monthly payment options!
Schedule your payment to be automatically deducted from your Visa, MasterCard, American Express or Discover Card.
Ask us about our Recurring Payment Option to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town)