MADELEINE C. WEISER MD, PC

Teuta Henci MD Alisa Hoffman MD

PATIENT INFORMATION

Patient Name	Date of Birth	Sex	Date
Address (Street number and name)	Address Line 2 (Apt/Unit/Floor)		
City, State Zip	Social Security #		
Home Phone Number	Parent Phone Number (Specify mom/dad)	Parent Phone Number (Specify mom/dad)	
Email address(es) (Specify mom, dad, guardian, patient, etc)			

Please indicate (by circling above) your preferred method of contact, either home phone, parent phone or email

PATIENT DEMOGRAPHIC INFORMATION

Patient Race (Circle all that apply)

Caucasian (White) Black Hispanic Asian (Includes Indian) Native American Asian Pacific American Pacific Islander Asian American

Preferred Pharmacy (Name & Phone Number)	Known Allergies (Specify Reaction) If no known allergies, please write NONE

Preferred Primary Physician (circle one)

Madeleine Weiser MD Teuta Henci MD Alisa Hoffman MD No Preference

PERSON RESPONSIBLE FOR CHARGES

Name of Responsible Party (Guarantor)	Date of Birth	
Address - Street	Guarantor Social Security #	
City, State Zip	Home Phone Number	Work Phone Number

INSURANCE INFORMATION

Name of Primary Insurance		Name of Secondary Insurance	
Policy Holder/Subscriber	Date of Birth	Policy Holder/Subscriber	Date of Birth
Insured ID/Policy Number	Group Number	Insured ID/Policy Number	Group Number
Insurance Effective Dates --	Copay Amount	Insurance Effective Dates --	Copay Amount

EMERGENCY CONTACT INFORMATION (Please try to use someone other than a parent)

Contact Name		Relationship	
Home Phone Number	Work Phone Number Ext	Cell Phone Number	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Responsible Party Signature Date

MADELEINE C. WEISER MD., PC

Teuta Henci MD Alisa Hoffman MD

Patient Information and Medical History

PLEASE PRINT CLEARLY

Patient Name: _____ M □ F □ DOB: _____/_____/_____

BIRTH HISTORY

Hospital: _____ Vaginal □ C-Section □ Adopted □

Birth Weight: _____ Weeks Gestation at Birth: _____ Complications: _____

PATIENT'S MEDICAL HISTORY

Illnesses/Conditions: _____

Current Medications: _____

Allergies: ·_____ Reaction: _____

·_____ Reaction: _____

Hospitalization/Surgery:

Date: _____ Details: _____

Date: _____ Details: _____

Date: _____ Details: _____

HOME LIFE

Primary language spoken at home:_____

Parents/Guardians □ Married □ Single □ Divorced - Lives with: _____

1. Name: _____ M □ F □ DOB: ___/___/_____ SSN_____/_____/_____

Relation to Patient: _____ Occupation: _____

2. Name: _____ M □ F □ DOB: ___/___/_____ SSN_____/_____/_____

Relation to Patient: _____ Occupation: _____

Do any household family members smoke? Yes □ No □

Address of parent/guardian (if different than patient): _____

Siblings City/State/Zip: _____

Name: _____ M □ F □ DOB: ___/___/_____

Name: _____ M □ F □ DOB: ___/___/_____

Name: _____ M □ F □ DOB: ___/___/_____

Additional members of household: _____

FAMILY HISTORY

Does anyone in your family have any of the following? Please indicate maternal or fraternal side of family

	No	Yes	Relationship To Patient		No	Yes	Relationship To Patient
Alcoholism	___	___	_____	High Blood Pres	___	___	_____
Allergies	___	___	_____	Kidney Disease	___	___	_____
Asthma	___	___	_____	Lead poisoning	___	___	_____
Cancer	___	___	_____	Mental Illness	___	___	_____
Diabetes	___	___	_____	Mental Retardation	___	___	_____
Drug Abuse	___	___	_____	Rheumatic Fever	___	___	_____
Early Infant Death	___	___	_____	Seizure Disorder	___	___	_____
G6PD	___	___	_____	Sickle Cell Disease	___	___	_____
Heart Disease	___	___	_____	Tuberculosis	___	___	_____

Please list other medical histories/conditions/illnesses of family members:

_____

MADELEINE C. WEISER MD, PC

Teuta Henci MD Alisa Hoffman MD

FINANCIAL POLICY

Madeleine C. Weiser MD, PC is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask you help by understanding and cooperating with our financial policy as is written below.

INSURANCES:
We participate with several different insurance companies. Please check with your insurance company to see if we participate with your plan. If we DO participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. **All copays and deductibles are the patient/guardian's responsibility and will be due at the time of service.**

If we do NOT participate with your insurance company, this means that we will not bill your insurance carrier AND we will not accept payment from them as payment in full for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

It is your responsibility to make sure that you provide us with your current insurance information. We will require you to present your insurance card at every visit. If we do not have current information you may be liable for the balance even if you were covered by insurance at the time of service.

IT IS IMPORTANT FOR YOU TO FULLY UNDESRTAND YOUR ISNRUANCE COVERAGE AND THS CONTRACT THAT YOU OR YOUR EMPLOYER HAS WITH THE COMPANY. We must emphasize that as medical providers, our relationship is with your, not your insurance company. It is often necessary for your rot inquire and explore your benefits with your insurance carrier. Due to the fact that we do accept a variety of insurances it is not possible for us to know all of your plan provisions. We will be happy to assist you with any questions that you have regarding non-covered services.

BILLING & PAYMENTS:
Our office accepts Visa, MasterCard, Discover, American Express, cash, and check. All payments are expected at the time of service. Any outstanding balances that are incurred as per your insurance company are due within 21 days of your billing statement. IF A SECOND BILL HAS TO BE SENT FOR ANY OVERDUE BALANCES, A $10.00 FEE WILL BE ASSESSED TO YOUR ACCOUNT. Should your account be sent to a collections agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance. Medical services will not be provided until all outstanding balances are paid in full unless other arrangements have been made with our billing department.

It is our office policy to charge the following fees that are not billed to your insurance.

$20 – Returned Checks (Plus the full amount of the original check)	$5 – Completed and Signed Medical Form
$35 – Sunday/Holiday Office Visits (In addition to your copay)	$20 – Driver's License Physical
$20 – Appointments missed without 24 hour cancellation notice	$35 – Ear Piercing

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY MADELEINE C. WEISER MD, PC AND I AGREE TO THE TERMS OF THE FINANCIAL POLICY.

_____ _____

Signature of Patient/Guardian Date

APPENDIX 6

MADELEINE C. WEISER M.D., PC

ALISA HOFFMAN M.D.

TEUTA HENCI M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Madeleine C. Weiser M.D., and other physicians named above, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Madeleine C. Weiser M.D., PC Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Madeleine C. Weiser M.D., PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at Madeleine C. Weiser M.D., PC.

With this consent, Madeleine C. Weiser M.D., PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Madeleine C. Weiser M.D., PC may e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Madeleine C. Weiser M.D., PC restrict how it uses or discloses my PHI or TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Madeleine C. Weiser M.D., PC may decline to provide treatment to me.

Signature of Patient or Legal Guardian / **Printed Name** of Patient or Legal Guardian

---

Patient's Name Date