Westside Family Medicine

315 W. 70th St, Suite 1B New York, NY 10023
535 W. 110 St, Suite 1E New York, NY 10025
P: (212)280-4740 F: (646)652-5377

PLEASE PRINT Date _____

Name_____

Address_____ Apt_____City_____
State____ Zip_____
Social Security Number_____
Birth Date _____
Home Phone _____Work Phone _____Cell Phone_____E-mail _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name and Phone_____
Relationship _____
Referred by _____

INSURANCE INFORMATION

Insurance Plan Name _____
Insurance Group Number _____
Insurance ID number _____
Primary Account Holder _____
Primary Account Holder's Birth Date _____
Relationship to Patient _____
Social Security Number _____

For Confidential Information (i.e. test results):
OK to leave detailed message at (check all that apply):
___ Phone work ___ phone home ___ cell phone ___ e-mail ___U.S. mail

Westside Family Medicine, PLLC
Patient Information, Financial Policy Statement and Agreement

Welcome to our practice. To ensure that our patients understand and agree to our policies regarding billing and procedures, please read all of the following, then initial and sign.

We participate in several insurance plans.. If we do not participate in your plan or you currently do not have medical insurance, or if you do not provide accurate insurance coverage information, you will be responsible for payment of the charges.

If we are a participating provider in your health insurance plan our office will submit a claim to your insurance carrier. You are responsible for payment at the time of service for any coinsurance, co-payment, deductible, as well as any non-covered service(s) and supplies under your contract.

If payment is made directly to the practice, you may attach your itemized bill to your claim form and submit it to your insurance carrier. The office accepts cash, checks and credit cards for payment. If a check is returned, you will be responsible for the amount of the check plus a $40.00 administration fee.

Please note that our office has a 24 hour cancellation and rescheduling policy.
There is a $40 fee for all appointments cancelled or rescheduled less than 24 hours in advance.
If you have insurance, it is your responsibility to know which services are covered under your plan, what your deductible and co-insurance responsibilities are, and whether or not your plan requires you to have a primary care provider listed. WFM will not become involved in disputes between patients and their insurance providers over non-covered services or patient deductible and co-insurance responsibilities.
Patients with certain types of insurance plans, including HMO and POS plans are required to have a primary care doctor selected in order to receive care by a primary care doctor. In order to be seen at this office, you must list either Dr. Bertie Bregman or Dr. Rachel Bregman as your PCP. After listing one of these doctors as your PCP, you may see any provider at this office.

Many insurance plans do not allow a patient to back date their PCP selection, and make it impossible for the provider to receive payment if we are not listed as the PCP. Therefore, we require PCP selection BEFORE the visit. If you have not yet listed us as PCP, please inform the receptionist NOW, and she will assist you in this process.

Authorization for Release of Information and Third Party Payment and HIPAA Compliance:

I authorize West Side Family Medicine and its medical providers to release information to third parties as required by my contracts with those carriers in the process of filing claims on my behalf and providing medical services. I assign all insurance benefits for treatment to be paid directly to the above named provider. I understand that I am financially responsible for all charges whether or not covered by said insurance. I have also been made aware of the privacy policy for this practice (HIPAA - Health Insurance Portability and Accountability Act).
Please initial the following:

_____ **I have confirmed DIRECTLY WITH MY INSURANCE that Dr. Bertie Bregman or Dr. Rachel Bregman are participating providers AT THIS LOCATION with my plan.**
_____ **I have listed Dr Rachel or Bertie Bregman as my PCP at THIS LOCATION**

_____ **I agree that I will be responsible for payment in full for any charges related to the visit that are not covered based on my individual benefits as stated by my insurance company, including deductibles, co-pays, co-insurance and non-covered services.**

_____ **I have read and understand the office cancellation policy. If I do not cancel or reschedule my appointment at least 24 hours in advance, or if I do not show, I will be responsible for a $40 fee.**

_____ **I understand that if I have a plan that requires me to list a PCP (HMO/POS or other), and do NOT list Dr. Bregman as my PCP, or if Dr Bregman is not a participating provider with my insurance plan, I will be responsible for an administrative fee of $250 in addition to the cost of vaccines and procedures for any date of service not covered by my insurance company.**

_____ I comply with HIPAA and the Westside Family Medical release statement.

_____

Patient name

_____

Patient signature

_____

Date