Yelena Sokolova, MD

3567 Shore Pkwy, 2nd Floor

Brooklyn, NY 11235

NEW PATIENT FORM - CONTACT & INSURANCE INFORMATION

PATIENT NAME : _____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL SECURITY: _____

_____

Home Phone: ( ) _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE CARRIER: _____ Member ID _____

SECONDARY INSURANCE CARRIER: _____ Member ID _____

INSURANCE PAYMENTS ASSIGNMENT:

I hereby instruct and direct my Insurance Carrier(s) to pay by check or electronically directly to my provider - - Yelena Sokolova MD. OR, If my current policy prohibits direct payment to doctor, I hereby agree to endorse the checks received from my insurance company and forward them to my provider - for the professional or medical benefits allowable, and otherwise payable to me under my current insurance policy,and payments towards the total charges for the professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
I also authorize the release of any information pertinent to my case to my insurance company, adjuster, or attorney involved in the case.

REIMBURSEMENT AGREEMENT IN EVENT OF INSURANCE NON PAYMENT OR DEDUCTIBLE:

I, the above captioned patient have been informed and understand that should my insurance company refuse payment for services rendered by Dr. Yelena Sokolova, for any reason, or, should my yearly deductible not be met, I will be personally liable and responsible for the charges for medical services provided by the afore-mentioned physician, and agree to reimburse Yelena Sokolova, MD upon notification of such a balance.

HOW DID YOU FIND OUT ABOUT US?

- □ Physician Referral _____
- □ Personal advice from _____
- □ Newspaper or magazine Ad: _____
- □ Direct Mailing
- □ Web Search _____
- □ Yelp
- □ Google
- □ Other _____

Do you want to receive information about your condition and other personal communication by e-mail?

- □ Yes. My e-mail address is _____ □ No.
- □ Click here if you also would like to join our mailing list and receive general health advise and inspirational messages from Dr. Sokolova.

_____ _____

Patient's Signature Date Witnessed by

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ understand that as part of my health care, YELENA SOKOLOVA, MD originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test result diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment;
A means of communication among the many health professionals who contribute to my care;
A source of information for applying my diagnosis and surgical information to my bill;
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent;
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or health care operations.

I understand that YELENA SOKOLOVA, MD. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that YELENA SOKOLOVA, MD reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should YELENA SOKOLOVA, MD change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
( ) Consent received by _____ on _____
( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical record on _____