New York Urologic
Farshad Shafizadeh, M.D
461 Park Avenue South
New York, NY 10016

Tel: (212) 777-8566 Fax: (646) 536-8738

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Patient Registration Form

Date: _____

Please Print legibly

Last Name: _____ First Name: _____ Date of Birth: _____

Social Security: _____ Sex: M__, F__ Marital Status: Married Single Widow

Home Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

Home Number: _____ Work Number: _____ Cell#: _____
Email:_____

Pharmacy Info: _____ Tel Number: _____
Address: _____

Your Occupation: _____Employer's Name: _____
Business Address: _____
Business Phone: _____

Spouse Name: _____ Cell Number: _____
Spouse Occupation: _____ Work Number: _____

Guarantor's Name: _____Guarantor's Phone: _____
Guarantor's Address: _____

Contact Name in Case of Emergency: _____ Tel Number: _____

Referring Doctor's Name: _____ Tel Number: _____
Address: _____

Primary Insurance: _____
Insurance ID: _____ Group Number: _____

Secondary Insurance: _____
Insurance ID: _____Group ID: _____

ALL FORMS ON THE NEXT PAGE MUST BE COMPLETED AND SIGNED BEFORE SEEING THE DOCTOR

FINANCIAL POLICY

Thank you for choosing us as your Urological health care provider. We are committed to providing you with excellent care. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment.

PRIVATE INSURANCE: Your insurance policy is a contract between you and your insurance provider. We are not a party to that contract. Therefore, YOU ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF VISIT.

PARTICIPATING INSURANCE: All copayments and deductibles are payable at the time of visit. Your signature below authorizes payments to us for our services. You are responsible for obtaining a referral number. If you do not, you are required to pay at the time of visit as an "out of network." If your insurance does not cover a special procedure and you would like it performed anyway, you are required to sign an acknowledgement and pay at the time of service. This waives your right to submit it to your carrier for denial.

MEDICARE INSURANCE: We accept assignment. We will electronically submit your claim.
Medicare will mail an Explanation of Benefits to you. You can then submit this to your coinsurance. We request that payment of authorized Medicare benefits be made to us on behalf of Farshad Shafizadeh, M.D., P.C. for services provided. I authorize any holder of medical information about me to be released to the healthcare financing administration agents any benefits for related services.

****MEDICARE BENEFICIARY NOTICE****

Medicare will only pay for services that it determines to be "reasonable and necessary" under 1872(a) (1) of Medicare law. I have been notified on the date indicated that ***Medicare is likely to deny payment for test/treatment if I exceeded the prescribed frequency for either the prescribed test/treatment***. I agree to be personally responsible for payment if Medicare denies payment.

****RELEASE OF INFORMATION****

I hereby authorize Farshad Shafizadeh, M.D., P.C. to release to insurance carriers or others who are, or may be financially responsible for my medical care, all information needed to substantiate payment for my medical care. I have read the above and agree to this policy as stated.

Print Name_____Date_____

Signature _____

ACKNOWLEDGMENT AND CONSENT HIPPA

By signing below, I acknowledge that I have read the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information, and generic information, finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____

1. Signature of Patient OR Patient's authorized Representative

_____

2. Print Name of Patient OR authorized Representative

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Attention Patient

Please be aware that we **require** at least **24 hours notice** if you will not be able to keep your appointment. Regretfully, we have found it necessary to impose the following fees for last minute cancellations and missed appointments:

Regular office visit $45.00
Procedures of any kind in the office $250.00
Procedures scheduled in the hospital or ambulatory surgery centers $800.00

Please note that these fees are not reimbursable by your insurance.

I understand the above office policy and agree to pay the above charges in case of missing my appointment for office visit, office procedures or outpatient procedures without 24 hour prior notice.

Patient's Name: _____

Patient's Signature: _____

Date: _____

Farshad Shafizadeh, M.D., P.C.

Urology & Urological Surgery

461 Park Avenue South, 5th Floor, New York, NY 10016

Patient Name:_____ Date of Birth: _____/_____/_____

Who sent you here?

Family_____Friend_____ Insurance Book_____Internet website _____

Dr: _____, Tel#_____

Do you have any of the following Urological Problems?

Enlarged Prostate	Elevated PSA	Sexual difficulty	Blood in the urine
Urine infections	Bladder Control	Kidney Stone	Prostate Cancer
Kidney Infection	Frequency of Urination	Testicular Pain	Infertility
Cyst in the Kidney	Urinary Incontinence	Bladder Infection	

Other, Please Explain: _____

Please circle any medical condition that you have **None**

High Blood Pressure	Diabetes	Angina/chest pain	Heart attack/Stroke
Poor Circulation	Slipped Disk	Arthritis	Cholesterol
Parkinson's	Alzheimer's	Glaucoma	Pinched Nerve
MS	Diverticulitis	Hernia	Ulcerative Colitis
Stomach Ulcer	Crohn's Disease	Heart Murmur	
Cancer (Type) _____		Other_____	

List all of the surgeries that you had: **NONE**

1)_____ 2)_____

3) _____ 4) _____

Do you have any ALLERGIES to following? **NONE**

X-Ray Dye Sea food/Shellfish Medication: _____

Do you have any of the following illnesses in your family? **NONE**

Diabetes Heart Disease Kidney Stone Prostate cancer Kidney Cancer

Bladder Cancer Other:_____

Social History

Do you smoke? No ___ Yes ___, How much? _____ How many years? _____

Drinking Alcohol? No ___ Yes ___, How much? _____ How many Years? _____

List all current medications: **NONE**

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Do you experience any of the following? **NONE**

Fever	Chills	Nausea	Vomiting	Diarrhea	Constipation
Weakness	Weight loss	Loss of Appetite	Chest Pain	Dizziness	
Palpitations	Sweating	Blurred Vision	Headache	Shortness of Breath	

Other: _____

_____ _____ _____

Patient Name (Print) Patient Signature Date