Winthrop Orthopaedic Associates, P.C.
Winthrop Medical Affiliates

James D. Capozzi MD
Mark G. Grossman MD
Glenn A. Teplitz MD
Omid S. Barzideh MD
John T. Gaffney DO
Bryan C. Ding MD
M. Lazar-Antman MD
Jason L. Gould MD
Rupinder Johal MD
Adam N. Wilson MD
Ioannis C. Zouzias MD

1300 Franklin Avenue
Garden City, NY 11530
(516) 747-8900

2339 Hempstead Tpk
East Meadow, NY 11554
(516) 747-8900

2000 N. Village Ave
Rockville Ctr, NY 11571
(516) 678-2232

7801 Myrtle Ave
Glendale, NY 11385
(516) 747-8900

Fax: (516) 663-8166
www.winthroporthopedicassociates.com
Practice Manager: Jackie Defeo

Patient Demographic Information Form

(Must be filled out completely by all patients)

Patient Name:	
Patient Home Address:	
Home Phone #:	**Cell Phone #:**
Date of Birth:	**Social Security #:**
Sex: Male Female	**Marital Status:** S / M / D / W

Name of Spouse:	
Date of Birth:	**Social Security #:**
Emergency Contact Name:	**Emergency Contact #:**
Relationship:	

** Meaningful Use requirement.*

***Ethnicity** *(please circle):* Hispanic / Non-Hispanic	***Preferred Language:**
***Race** *(please circle):* American Indian/Alaska Native Asian Black /African American Hispanic/Latino Native Hawaiian/Other Pacific Islander White	

Patient Employer:	**Spouse Employer:**
Employer Address:	**Employer Address:**
City, State, Zip:	**City, State, Zip:**
Employer Phone #:	**Employer Phone #:**

Who is your Primary Physician?
Physician Address:
Physician Phone #:

How were you referred to our office?	Another Physician Hospital Emergency Room
Physician Name	**Hospital:**
Address:	**Address:**

Pharmacy Name:	
Pharmacy Phone #:	**Pharmacy Fax #:**
Pharmacy Address:	

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Patient Insurance Information Form

(Must be filled out completely by all patients)

Primary Insurance: _____

Policy ID#: _____

Group #: _____

Effective Date: _____ Expiration Date: _____

Policy Holder: _____ Policy Holder's DOB: _____

Policy Holder's SS#: _____ Policy Holder's Sex: M F

Policy Holder's Address: _____

Relationship to Patient: Self Spouse Parent Guardian

Secondary Insurance: _____

Policy ID#: _____

Group #: _____

Effective Date: _____ Expiration Date: _____

Policy Holder: _____ Policy Holder's DOB: _____

Policy Holder's SS#: _____ Policy Holder's Sex: M F

Policy Holder's Address: _____

Relationship to Patient: Self Spouse Parent Guardian

IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE RECEPTIONIST FOR THE APPROPRIATE FORMS. THIS IS YOUR RESPONSIBILITY!

Did injury occur at school? _____
School Name: _____
School Phone#: _____
School Insurance Carrier Name: _____
School Insurance Address: _____
City, State & Zip: _____
Date of Injury: _____
If injury occurred during a school sport, please give name of sport: _____

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PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of Winthrop Orthopaedic Associates, PC Practice's Privacy Notice.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

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RELEASE OF INFORMATION

PATIENT NAME: _____ DATE: _____

PATIENT DOB: _____ PATIENT ACCOUNT: _____

By completing this agreement, I hereby authorize Winthrop Orthopaedic Associates, P.C., to release, either verbally or orally, any or all information concerning my medical care to the below named individuals:

_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient

PATIENT SIGNATURE: _____

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INSURANCE WAIVER

I. Individual's Responsibility for Non-Covered Services:

In consideration of services rendered by Winthrop Orthopaedic Associates, PC to the undersigned patient, the undersigned promise(s) to pay Winthrop Orthopaedic Associates, PC any co-payment, co-insurance or other charges required be paid by health insurance coverage.

II. Assignment of Benefit Proceeds:

I request that payment of authorized HMO/Third-Party Payor/Government Agencies (Medicare and Medicaid) benefits be made either to me or on my behalf of Winthrop Orthopaedic Associates, PC for services furnished to me by the provider.

III. Authorization to Release Records:

I hereby authorize Winthrop Orthopaedic Associates, PC to release to my insurer/HMO/Third-Party Payor, governmental agencies, or to whomever is financially responsible for my medical care, all information, needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

IV. Medicare Patients:

Upon receipt of the Medicare Explanation of Benefits, we will bill you for the difference between what Medicare has paid us and the amount Medicare legally allows us to charge you, we will bill your secondary insurance if you have one. ACCEPTED ASSIGNMENT DOES NOT EXEMPT YOU FROM PAYMENT OF BALANCE DUE.

V. HMO Plans (VYTRA, OXFORD, AETNA, etc.):
For plans requiring referrals from the primary care physicians, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, you will be billed according to the regular fee schedule.

VI. Private Insurance:

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT.

_____ _____

Signature of Patient or Authorized Representative Date