Anita-Kay Martin, MD., PC
OBSTETRICS/GYNECOLOGY & WOMEN'S HEALTHCARE
205-07 Hillside Ave, Suite #28
Hollis, NY 11423
Phone: (718) 217-9207
Fax: (718) 217-9334

Patient Demographic Form

Please print clearly and complete ALL pages. This document is part of your permanent record.

Patient Full Legal Name:_____ Gender: ☐M ☐F
DOB:_____ Age: _____
Patient Address:_____
City:_____ State:_____ Zip:_____
Patient SS #:_____-_____-_____
Home Phone#:_____Cell Phone#:_____Work Phone#:_____Ext:___
Email:_____

Emergency Contact

Name: _____Primary Phone#:_____
Spouse Name:_____ Spouse Phone#:_____
Spouse Employer:_____ Work Phone #:_____

Physician Information

(Include first AND last name of physician)

Who referred you to our office? _____ Phone _____
Primary Care Physician:_____ Phone_____

Employment Information

Employed: ☐ **Full-Time** ☐ **Part-time** / ☐ **Retired** / Student: ☐ **Full-Time** ☐ **Part-time**
Name of Employer or School: _____
Employer Address:_____

Pharmacy Information

Will your Prescriptions be going to a pharmacy or Mail Order? ☐ **Pharmacy** ☐ **Mail Order**
Pharmacy Name/Address:_____
Mail Order Pharmacy/Address:_____

Insurance Information

Primary Insurance:_____
ID #: _____Group #:_____
Policy Holder Name:_____ Policy Holder DOB:_____
Relationship to Insured:_____

Secondary Insurance:_____
ID #: _____Group #:_____
Policy Holder Name:_____ Policy Holder DOB:_____
Relationship to Insured:_____

Assignment of Benefits: I authorize payment of medical benefits directly to Anita-Kay Martin, MD., P.C. for services rendered. I understand that I am responsible to pay for service, reasonable attorney fees and cost of collection in the event of default. I authorize any holder of medical or any other information about me released to the social security administration, healthcare financing administrations or its intermediaries, carries or the billing agent of the physician. Any information used in place of the original and request payment of medical insurance benefits either to me or the party who accepts assignment.

Signature:_____Date:_____

Anita-Kay Martin, MD., PC
OBSTETRICS/GYNECOLOGY & WOMEN'S HEALTHCARE
205-07 Hillside Ave, Suite #28
Hollis, NY 11423
Phone: (718) 217-9207
Fax: (718) 217-9334

What is an Advance Directive

An Advanced Directive is a document allowing a person to give instructions to another about his/her future medical care in the event that he/she loses their decision-making capabilities. Advanced Directives may include LIVING WILL durable POWERS OF ATTORNEY for health care decisions, **DO-NOT-RESUSCITATE (DNR's)** orders, right to die or similar documents expressing the individual's preferences.

I understand that this is not a legal document or living will. This form is for used to indicate if such documents exist and was executed by an attorney and also discussed and on file with my primary care provider (PCP).

Advance Directive Notification Form

I have executed an Advance Directive	YES	NO
I have discussed this Advance Directive with my Primary Care Physician	YES	NO

Signature_____Date_____

If you have answered **YES** to both questions, please provide the name and address of the designee, and the name and phone number of the primary care physician that has this information on file.

Designee Name:_____

Designee Address:_____

_____

Primary Care Physician:_____

Anita-Kay Martin, MD., PC
OBSTETRICS/GYNECOLOGY & WOMEN'S HEALTHCARE
205-07 Hillside Ave, Suite #28
Hollis, NY 11423
Phone: (718) 217-9207
Fax: (718) 217-9334

INSURANCE POLICIES, PATIENT RESEPONSIBLITY, AND DISCLOSURE STATEMENT

Here at Dr. Anita-Kay Martin's office, we want to educate our patients regarding insurance and help you understand what your responsibility is as the patient. This practice has contracts with many insurance companies and us as the provider will bill them as a service to you. You as the patient/guarantor are responsible for any and all claims that your insurance company declines. Any Inaccurate information can delay claim processing and can possibly lead to fees being transferred to you as patient responsibility. Below are guidelines to ensure that your claim will be processed in a timely manner.

THE PATIENT OR RESPONSIBLE PARTY SIGNING MUST:

- Inform Dr. Anita-Kay Martin, MD. P.C. of the current address and phone number.
- Present Identification cards and insurance cards at time of appointment.
- Inform the staff of any changes to insurance, address, and phone number.

OFFICE POLICIES PERTAINING TO PATIENT RESPONSBILITY:

- **CO-PAY:** This is due at time of visit.
- **DEDUCTIBLE:** Fees that you as the patient are responsible for prior to your insurance company paying for services rendered (If applicable). We are allowed to collect this payment at time of service. Depending on your insurance plan, payment can range from $40.00-$200.00. We as the provider will notify you prior to your appointment if you have a deductible and what is expected at time of service.
- **CO-INSURANCE:** Fees that you as the patient are responsible to pay for after services have been rendered (if applicable). Co-insurance payments will be billed to you.
- **OTHER SERVICES AND FEES:** In some cases we as the provider are unaware of certain fees for services until we receive an EOB (Explanation of Benefits) from your insurance company. We as the provider can bill you for these services.
- **PAYMENT PLANS:** We do provide payment plans, please ask office personnel for further information.
- **OUTSTANDING BILLS:** Outstanding bills that are not paid within a 60 day period may be sent to credit reporting agencies.
- **REFERRALS/AUTHORZATIONS:** Referrals and authorizations are you as the patient's responsibility to obtain prior to your visit.
- **CANCELLALTIONS/MISSED APPOINTMENTS:** We ask that cancellations be made 24 hours prior to your appointment. Late cancellations or missed appointments are subject to a $25 late/miss appointment fee.

Our mission is to provide every patient with quality service and care. If you have any questions about your policy please contact your insurance company. If you have any questions regarding charges please contact our office or our billing company.

Your signature below forms a binding agreement between Dr. Anita-Kay Martin, MD. P.C. and the patient who is receiving medical services, or the responsible party for minor patients (those who are under 18 years of age). The responsible party is the person(s) financially responsible for payment of medical bills. You also agree that all information you have provided Dr. Anita-Kay Martin, MD. P.C. is accurate and up to date.

****I understand that any and all claims may not be covered entirely by my insurance and that any remaining balances are my responsibility.**

****I understand that any outstanding bills not paid within a 60 day period (unless a payment plan was administered) are subject to be sent to collections and any future appointments will not be scheduled until bill is satisfied.**

****I understand that I will be charged a $25 fee for all missed appointments and appointments not cancelled within 24 hours of a scheduled visit.**

****I understand everything that I have read and agree to the terms listed.**

Patient/Resp. Party Signature_____**Date**_____

Patient/Resp. Party Print Name_____

Anita-Kay Martin, MD., PC
OBSTETRICS/GYNECOLOGY & WOMEN'S HEALTHCARE
205-07 Hillside Ave, Suite #28
Hollis, NY 11423
Phone: (718) 217-9207
Fax: (718) 217-9334

PATIENT CONSENT FOR USE AND DSICLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Dr. Anita-Kay Martin, MD, P.C. to use and disclose **PROTECTED HEALTH INFORMATION (PHI)** about me to carryout **TREATMENT, PAYMENT AND HEALTHCARE OPERTATIONS (TPO).** I acknowledge and read the NOTICE OF PRIVACY PRACTICES provided by Dr. Anita-Kay Martin, MD, P.C. which describes such uses and disclosures more completely.

I have the right to request that Dr. Anita-Kay Martin, MD. P.C. restricts how it uses or discloses my PHI to carry out my TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, Dr. Anita-Kay Martin, MD. P.C. **MAY CALL MY HOME** and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and/or test results among other items pertaining to my clinical care. **YES NO**

With my consent, Dr. Anita-Kay Martin, MD. P.C. **MAY CALL MY CELL PHONE** and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and/or test results among other items pertaining to my clinical care. **YES NO**

With my consent, Dr. Anita-Kay Martin, MD. P.C. **MAY MAIL TO MY HOME** or other designated location in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards, insurance items, and notifications as long as they are marked PERSONAL AND CONFIDENTIAL. **YES NO**

With my consent, Dr. Anita-Kay Martin, MD. P.C. **MAY E-MAIL MY HOME** or other designated email address in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. **YES NO**

By signing this form, I am consenting to Dr. Anita-Kay Martin, MD, P.C. the use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Anita-Kay Martin, MD, P.C. may decline to provide treatment to me.

Patient/Legal Guardian Signature_____**Date**_____

Patient Print Name _____

Legal Guardian Print Name (if applicable)_____