

Demographic Form

Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security #: _____ Age: _____
Home Phone: _____ Work Phone: _____
Occupation: _____ Employer: _____
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Partner's Name: _____ Age: _____ Occupation: _____
Date of Birth: _____ Contact Number: _____ Employer: _____

Referring Physician's Name (if applicable) _____
Physician's Address: _____ City: _____ State: _____ Zip: _____
Physician's Phone: _____ Physician's Fax: _____

Primary Care Insurance Company: _____
Policy #: _____ Group #: _____
Claims Address: _____ Phone: _____
Patient's Relationship To Insured: Self _____ Spouse _____ Child _____ Other _____
Name of subscriber(if other than patient): _____
Subscriber's Social Security #: _____ Gender: _____ Date of Birth: _____
Secondary Insurance Company: _____
Claims Address: _____ Phone: _____
Patient's Relationship To Insured: Self _____ Spouse _____ Child _____ Other _____
Name of subscriber(if other than patient): _____
Subscriber's Social Security #: _____ Gender: _____ Date of Birth: _____

First day of most recent menstrual period: _____
Is patient pregnant? Yes _____ Unknown _____
Total # of pregnancies including current & miscarriages? _____
Known # of fetuses this pregnancy? _____

Please read the following and sign below:

Assignment of Benefits and Release Information
I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Medicare Patients
I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

Notice of Privacy Practices Acknowledgement
By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

**ROSH Maternal Fetal Medicine
Daniel Roshan, M.D.
213 Madison Avenue, Suite 1A
New York, NY 10016
(212) 725 - 0123**

PATIENT FINANCIAL LIABILITY STATEMENT

I understand that I am personally responsible for charges incurred for services rendered by ROSH Maternal Fetal Medicine if any of the following apply:

- My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at ROSH Maternal Fetal Medicine and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral.

And/or

- My health plan determines that the services I receive at ROSH Maternal Fetal Medicine is not medically necessary.
- My health plan coverage has lapsed or expired at the time I receive services at ROSH Maternal Fetal Medicine.

And/or

- I have chosen not to use my health plan coverage.

I also understand that I am responsible for all co-payments and co-insurance sums under my health plan. My credit card will be charged for all the above reasons.

Print Patient Name: _____

Print Guarantor's Name if not Patient: _____

Signature of Financial Responsible Party: _____

Credit Card Type: _____ Name on Card: _____

Card Number: _____ 3 Digit Security Code: _____

Expiration Date: _____ Today's Date: _____

INFORMATION ABOUT YOUR APPOINTMENT

We are pleased that you have chosen ROSH Maternal Fetal Medicine for your medical care. We will make every effort to assist you in obtaining insurance per-authorization for your medical care. There are, however, many medical procedures that are not covered by insurance. You are ultimately responsible for all payment for your medical care.

You agree to accept financial responsibility for co-payments and co-insurance, deductibles and all other medical care you receive. Furthermore, you agree to accept responsibility for understanding your insurance plan's benefits and limitations, as well as the regulations regarding pre-authorizations and referrals. If medical care is rendered without the appropriate pre-requisites, or without insurance coverage, you agree to assume financial responsibility for those services that were denied.

Patient's Name: _____

Signature: _____ **Date:** _____