MK HEALTHCARE MEDICAL PC
PATIENT INFORMATION
(PLEASE PRINT)

PATIENT INFO:

Name_____ Male_____ Female _____ Birthdate _____

Address _____ Apt. # ____ City _____ State____ Zip Code _____

Tel. # ( ) _____ Cell # _____ SSN # _____EMAIL:_____

Emergency Contact_____ Relationship _____

Address _____ Apt. # ____ City _____ State ____ Zip Code _____

Tel.# ( ) _____ Beeper # _____

Family Physician _____

Address _____ Ste. # _____ City _____ State ____ Zip Code _____

Referred By _____ Address _____ Tel. # ( ) _____

EMPLOYMENT INFORMATION:

Name of Employer _____

Address _____ Ste. # _____ City _____ State ____ Zip Code _____

Tel. # ( ) _____ Ext _____ Contact Person _____

Is this injury or illness accident related? ☐ Yes ☐ No If Yes ☐ work ☐ auto ☐other _____

ACCIDENT INJURIES – WORKERS COMPENSATION

Name of Carrier _____ Date of Accident _____

Address _____ City _____ State _____ Zip Code _____

Carrier Case # _____ WCB # _____ Unit _____

Location _____ Time _____ Supervisor _____

Are You Working? ☐ Yes ☐ No Date You Stopped _____

NO-FAULT

Name of Carrier _____ Date of Accident _____

Address _____ City _____ State _____ Zip Code _____

Tel. # ( ) _____ Name of Agent _____

Name of Insured: _____ Are You Working? ☐ Yes ☐No Date You Stopped _____

Insured's Address _____ City _____ State _____ Zip Code _____

Insured's Policy # _____ Claim/File # _____

ATTORNEY

Name of Firm _____ Name of Attorney _____

Address _____ Ste. # _____ City _____ State _____ Zip Code _____

Tel. # ( ) _____ Attorney's File # _____

INSURANCE INFORMATION

Name of Primary Carrier _____

Address _____City _____ State _____ Zip Code _____

Tel. # ( ) _____ Name of Insured _____ DOB _____

Policy # _____ Group # _____ Effective Date _____

Insured's SSN# _____ Have You Met Your Deductible? _____

Name of Secondary Carrier _____

Address _____ City _____ State _____ Zip Code _____

Tel. # _____ Name of Insured _____ DOB _____

Policy # _____ Group # _____ Effective Date _____

Insured's SSN # _____ Have You Met Your Deductible? _____

I verify the accuracy of the above information. It is my understanding that the Insurance doesn't not pay, I am responsible for payment.

Patient's Signature_____ **Date** _____

MK HEALTHCARE MEDICAL, PC
56-29 METROPOLITAN AVENUE
RIDGEWOOD, NY 11385

MEDICAL INFORMATION DISCLOSURE (HIPPA)

Effective April 14, 2003

MK HEALTHCARE MEDICAL PC is in charge of privacy matters in our Office. You may contact regarding any problems or concerns regarding your medical information and HIPAA questions.

Federal law provides that we may use your protected health information, without your specific authorization, for treatment of you (such as when speaking to a specialist who is on the case), for payment of services (such as filling out your insurance forms), or for health care operations (such as accountants Medicare audits, etc.) We may also disclose information when it's required by law; such as for public health purposes, child/elderly abuse, coroner/medical examiner, organ donation; funeral director, department of health or OPMC, judicial-administrative proceeding, law enforcement officials, or to avert serious health or safety threats. New York state law provides additional protection for information regarding HIV/AIDS, which will continue to respect.

We may contact you by mail or phone, at your residence or place of work to remind you of appointments or to provide information about you; unless you instruct us otherwise, we may leave a message for you on the answering device or with the person who answers the phone. You may make responsible requests, in writing , for us to use alternate methods of communicating with you in a confidential matter. Other users or disclosures of your medical information will be made only with you're written authorization. You have the right to revoke or revise any written authorization that you give.

You have the right to request restrictions on certain of the uses or disclosures described above; except as state below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charge). You have the right to request amendments to your medical information. Such request must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree; if we disagree we will further notify you of your rights. You have the right to request an accounting of any disclosures we make to you, or as permitted by law as stated above, or for those made before April 14, 2003.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is in effect. We reserve the right to revise the notice; if so, you will be given a copy of the new notice.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with this Office, or with the Secretary of the Department of Health and Human Services of the United States. No retaliatory action will be taken against you for any complain you may take.

Signature _____ Name _____ Date: _____