ROBOTIC GYNECOLOGY

REGISTRATION FORM: Please fax to (212) 448-1049 or email to rsurgery201e@.com

DEMOGRAPHICS		
Last name:	First name:	
Date of Birth:	Social Security Number:	
Address:		
City:	State:	Zip code:
Phone Number:	Alternative Number:	
Email Address:		
Emergency Contact Name:		
Emergency Phone #:	Relationship:	
INSURANCE		
Insurance Company Name:		
Policy #:	Group #:	
PHARMACY		
Pharmacy Name:		
Address:	Phone #:	

REFERRAL SOURCE			
☐ Friend	☐ Web Search	☐ Physician (please indicate):	☐ Other (please indicate):

Health Insurance Portability and Accountability Act (HIPPA)

Please be advised that we are being required by law to offer and provide you with a copy of our policies and procedures. We are also required by law to show proof that you were offered a copy of these procedures. Therefore, we will be asking you to sign this form indicating that we complied with this law. A copy of our policies and procedures will be available upon request. Please note this form does not give us authorization to release information to any person to facility that is not authorized to receive it without your signed authorization.

I, ______________________, acknowledged that I have been offered and provided with a copy of Dr. Joon Song's privacy notice.

Signature: Date:

Financial Policy and Patient Responsibility

Summary of Financial Policies for Our Office

Thank you for choosing Dr. Song at NY Robotic Gynecology & Women's Health for your medical care. We appreciate that you have entrusted us with your health and we are committed to providing you with the best care we can. Health care benefits and coverage options have become increasingly complex, so this financial policy is to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or employer. Please note it is your responsibility to know if your insurance has **any specific rules or regulations, such as the need for referrals to/from other doctors, pre-certifications/pre-authorizations, limits on outpatient charges, radiology procedures and any requirements for specific physicians, labs, and/or hospitals to use.** You should be knowledgeable of **any deductibles, co-payments, and/or co-insurance.** If you are uncertain about your insurance policy benefits, please contact your plan to learn more.

Insurance Coverage

Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will keep a copy of your insurance card on file for our records.

Please be aware of and provide any required referrals or authorizations your insurance requires in advance of your appointment. If you do not provide these before care is provided, you will be responsible for the cost of care. When in doubt, contact your plan directly for clarification.

Dr. Song belongs to many insurance plans, but not all. Before your appointment, please be sure that Dr. Song is in-network and the services he offers are covered under your plan. If your insurance plan is out-of-network, you will be billed for the costs of care. We will help you find out if you have out-of-network benefits and submit a claims to your plan on your behalf. Please let us know at anytime if you do not want us to submit a claim to your plan.

Address Change

It is important that we have your correct address information on file. Please advise us anytime if there is any change to your address, telephone, or other contact information.

Co-payments/Co-insurances/Deductible

You are expected to pay your copayment at the time of service. If you have co-insurance and/or deductibles, payment is not due at time of service, but may show up later in a bill from our office.

Payments

Co-pays are due at the time services are provided, and other payments are due upon receipt of a statement from our billing office. We accept payment in the form of cash, check, or debit/credit card. Returned checks are subject to a fee of $20.00. We do not accept traveler's checks.

When you have a balance on your account, we send a statement to the mailing address you provide us. By providing your address, you consent to receiving these statements.

Out-of-Network Providers

If Dr. Song is not in your insurance plan, the following apply:

-Full payment is due at the time of service for routine visits

-Payment expected on the date of service may be an estimate of your total charges.

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-You will be quoted an estimated fee before services/procedures are performed.
-After your appointment, we will submit a claim to your plan for services performed.
-Even if you have out-of-network benefits, you are ultimately responsible for the full fee charged
-Depending on your plan, payment may be sent to you. If you receive this payment, you must reimburse our office immediately.

Failure to pay

If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency you will need to contact them directly to settle your balances.

Policy and Fee Changes

These policies and fees are subject to change. We will do our best to keep you informed of any modifications.
We know medical care can be expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask our medical biller at 212-448-1048.
-A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
-We charge **$.75** per page to copy or transfer medical records.
-If you have school, camp, disability, or sport forms to be completed, there is a **$10** charge per form. Payment is due when the forms are dropped off. We have a 3 to 5-day turnaround time for forms. If a form is needed sooner than 3 days, there is an additional **$10** rush fee.

Financial Liability

I have been provided a copy of NY Robotic Gynecology & Women's Health's financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
-My health plan requires prior referral by a Primary Care Physician (PCP) before seeing Dr. Song and I have not obtained such a referral, or I receive services in excess of the referral, and/or
-My health plan determines that the services I received at Dr. Song's office are not medically necessary and/or not covered by my Insurance plan, and/or
-I have chosen not to use my health plan coverage, and/or
-Dr. Song does not participate with my health care plan.

I understand what is expected of me and agree to the policy.

Name:

Signature: Date:

Great Wall Medical P.C.	HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM Please Fax signed consents to: 917-829-2096	Patient MRN:

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Health System Health Information Exchange ("HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU Langone health providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the HIE. In order for a Care Everywhere Provider to know that information may be available through the HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staffs of NYU Langone Health System and affiliated entities to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization, a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Health System and affiliated entities program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling 877-695-4749. Upon request, your provider will print this list for you from this website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology. To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care". You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box below:

1. I GIVE CONSENT to ALL of the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access ALL of my electronic health information through the HIE and **I GIVE CONSENT** to ALL employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

2. I DENY CONSENT to the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access my electronic health information through the HIE and **I DENY CONSENT** to employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access my electronic health information through HEALTHIX for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the HIE and HEALTHIX. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Print Name of Patient — Patient's Date of Birth — Date

Signature of Patient or Patient's Legal Representative — Print Name of Legal Representative and Relationship (if applicable)