BROOKLYN PLAZA MEDICAL CENTER, INC.
650 FULTON STREET
BROOKLYN, NY 11217
TELEPHONE (718)596-9800, FAX (718) 596-9812

PATIENT ACCOUNT#_____ **PATIENT CHART#**_____

HOW DO YOU HEAR ABOUT BROOKLYN PLAZA MEDICAL CENTER, INC.?_____

PATIENT INFORMATION (PLEASE PRINT)

LAST: _____ FIRST: _____ MIDDLE: _____
HOME ADDRESS: _____APT: _____ CITY: _____ STATE: ____ ZIP: _____
CELL PHONE: _____ ARE YOU A RESIDENT OF PUBLIC HOUSING? _____ HOMELESS: YES__ NO__
PHARMACY NAME: _____ ADDRESS: _____
DATE OF BIRTH: _____ EMAIL: _____
MARITAL STATUS: M S D *VETERAN*: YES NO *SEX AT BIRTH*: M F LANGUAGE: _____ SSI#: _____

ETHNICITY/RACE, *(CHECK ALL THAT APPLY):*

__ASIAN __HISPANIC OR LATINO __BLACK/AFRICAN AMERICAN
__AMERICAN INDIAN __ALASKA NATIVE (INCLUDING AMERICAN INDIANS OR ALASKA NATIVE)
__OTHER PACIFIC ISLANDER __WHITE (INCLUDING WHITES OF LATINO/HISPANIC DECENT)
__MORE THAN ONE RACE __UNREPORTED/ REFUSED TO REPORT

SEXUAL ORIENTATION/ PREFERENCE

SEXUAL ORTIENTATION (CHECK ONLY ONE)

__LESBIAN/ GAY __SOMETHING ELSE __DON'T KNOW
__STRAIGHT (NOT LESBIAN/GAY) __BISEXUAL __CHOOSE NOT TO DISCLOSE

SEXUAL IDENTITY (CHECK ONLY ONE)

__MALE __TRANSGENDER MALE (BORN FEMALE, IDENTIFY AS MALE) __OTHER
__FEMALE __TRANDGENDER FEMALE (BORN MALE, IDENTIFY AS FEMALE) __CHOOSE NOT TO DISCLOSE

RESPONSIBLE FOR BILLING OTHER THAN SELF E.G. (SPOUSE, PARENT, GUARDIAN)

LAST: _____ FIRST: _____ MIDDLE: _____
SSI#: _____ RELATIONSHIP TO PATIENT: _____
HOME ADDRESS: _____APT: _____ CITY: _____ STATE: ____ ZIP: _____
TELEPHONE: _____
WHO CAN WE CONTACT INCASE OF AN EMERGENCY?
LAST: _____ FIRST: _____ MIDDLE: _____
HOME ADDRESS: _____APT: _____ CITY: _____ STATE: ____ ZIP: _____
TELEPHONE: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER'S INFORMATION

NAME: _____ TELEPHONE #: _____

INSURANCE INFORMATION

YOUR RELATIONSHIP TO THE INSURED, CHECK ONE ___ SELF ___SPOUSE ___CHILD ___OTHER SPECIFY
MEDICARE YES/NO ID# _____
MEDICAID YES/NO ID#_____
MEDICAID MANAGED CARE: YES/ NO NAME: _____ ID#:_____
PRIVATE INSURANCE: YES/NO NAME: _____ ID#:_____
POLICY# _____ GROUP#: _____

REGULAR SALARY: _____ OTHER SOURCE OF INCOME: _____ TOTAL INCOME: _____
TOTAL FAMILY MEMBERS: _____ **OFFICE USE ONLY:** AMOUNT TO BE PAID PER VISIT: _____
PATIENT/ GUARDIAN'S SIGNATURE: _____ DATE: _____

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CONSENT FOR MEDICAL TREATMENT

I, _____, so herewith voluntarily consent to such care including routine

diagnostic and therapeutic medical treatment for_____ to be
Patient's Name

provided by the Physicians, Medical Staff and Personnel at this Health Center.

I acknowledge that no guarantees have been made to me as to the results of treatments or examination in this health center. This consent has been fully explained to me and I certify that I understand its content.

_____ _____ _____

Witness **Patient's Signature, Parent or Guardian** **Date**

SPECIAL CONSENT

I, _____ herewith authorize the Physicians, Medical Staff and Personnel of

this Health Center to treat _____ for the conditions that appear as indicated and have
Patient's Name

been explained to me as I understand the nature of the procedure as explained to me by _____
Provider

_____ _____ _____

Witness **Patient's Signature, Parent or Guardian** **Date**

RELEASE – REFUSAL OF TREATMENT

I, _____, refuse to allow and specifically forbid anyone to perform:

_____

on _____ as such medical treatment is contrary to my wishes.
Patient's Name

I fully understand that refusal of this treatment or procedure may seriously imperil my life (or the life of whom I'm the legal guardian) or may result in serious disability. I herewith release Brooklyn Plaza Medical Center, Inc. all it's Doctors, Nurses, Employees and Agents from all liabilities.

_____ _____

Patients Signature, Parent or Guardian **Date**

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NOTICE OF PRIVACY ACKNOWLEDGEMENT / CONSENT FORM

I_____ the undersigned patient or other person legally authorized to act for the patient, have been provided with a copy of the Notice of Privacy Practices for Protected Health Information, and I have had the right to review the Notice prior to signing this Consent.

Consent for Use and Disclosure of Protected Health Information:

_____ the undersigned patient or other person legally authorized to act for the patient, understand and agree that all health information concerning the above - named patient, "Protected Health Information" (PHI) shall remain the property of Brooklyn Plaza Medical Center, Inc. (BPMC). I consent to the use and disclosure of such PHI in BPMC's Notice of Privacy Practices. Except for the reasons described in the Notice, I may revoke this Consent in writing at any time using the procedure outlined in the Notice.

This is to certify that I, the undersigned patient or other person legally authorized to act for the patient have read this Consent for Use and Disclosure of Protected Health Information and acknowledgement of Receipt of Notice of Privacy Practices, understand its content, and accept its terms. I agree that this Consent supersedes all previous consents, authorizations, releases, and other written legal permissions signed by me regarding Use and Disclosures of the PHI covered by this Consent, and I release BPMC and its health care providers from all liabilities related to their compliance with this consent.

_____ _____

Print Patient's Name **Patient's Signature, Natural or Legal Guardian**

_____

Date

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that Brooklyn Plaza Medical Center, Inc. (BPMC) may accept assignment of insurance benefits. However, it will require that I guarantee payment of unpaid deductibles and / or charges by credit card or pay a minimum of 50% of the charges in case, at the time of service. I understand that BPMC cannot bill my insurance company unless I provide complete insurance information and an original claim form. I understand that my insurance policy is a contract between the insurance company and myself and that BPMC is not a party to that contract.

I understand that by guaranteeing payment by credit card I am authorizing BPMC to charge my credit card for unpaid balances, unapproved charges and / or unpaid deductibles. I understand that some and perhaps all of the services provided may be non – covered services and not considered reasonable and necessary or that the charges may exceed that which is deemed usual and customary under the Medicare Program and / or other medical insurance but that this will not release me from responsibility for payment for those services.

I also understand that if I elect to pay cash for services that I will be billed for any unpaid balances and will be held financially responsible for payment.

I understand and agree to this statement

Signature of Responsible Party Date