



# New York House Call Physicians®

DBA DOCTOR IN THE FAMILY

REVISED FEBRUARY 20, 2021

## DOCTOR IN THE FAMILY NEW PATIENT FORM

**NOTICE OF PRIVACY PRACTICE & SECURITY:** In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), DOCTOR IN THE FAMILY also DBA NATAN SCHLEIDER MD PLLC or NEW YORK HOUSE CALL PHYSICIANS will keep all of your health information confidential. This means that your medical records anything related to your health will NOT be released without your written consent and explicit permission.

**NOTE FOR MEDICARE & MEDICAID PATIENTS:** DOCTOR IN THE FAMILY does not participate with Medicare or Medicaid. Medical services covered by Medicare and Medicaid may not be billed to Medicare or Medicaid. You will not be reimbursed for services mediated by DOCTOR IN THE FAMILY.

***DON'T FREAK OUT!***

***DOES YOUR INSURANCE COMPANY CLAIM YOU OWE US MONEY?***

***99% OF THE TIME THEY ARE WRONG!***

**QUESTIONS? CALL/TEXT 646.957.5444**

**MY SIGNATURE BELOW INDICATES I HAVE READ AND AGREE TO THE ABOVE:**

**Patient or Guardian Signature** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

New York House Call Physicians® DBA DOCTOR IN THE FAMILY

Office: 35 East 35<sup>th</sup> Street, New York, NY 10016

www.doctorinthefamily.com • [info@doctorinthefamily.com](mailto:info@doctorinthefamily.com) • Phone 646.957.5444 • Fax 917.591.6885

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Revised October 2<sup>nd</sup>, 2020

## DOCTOR IN THE FAMILY NEW PATIENT FORM

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Email: \_\_\_\_\_

Patient Health Insurance Plan Name: \_\_\_\_\_

Patient Insurance Plan Member ID Number: \_\_\_\_\_

**NOTE ON COMMUNICATION:** EFFECTIVE, SECURE, AND TIMELY COMMUNICATIONS ARE IMPORTANT TO PROVIDE QUALITY MEDICAL CARE. PHONE, TEXT, VOICEMAIL, EMAIL, PAPER MAIL ALL MAY BE USED. ALL TEST RESULTS ARE REPORTED WHETHER NORMAL OR ABNORMAL. PLEASE NOTIFY US IF YOU HAVE HAD TESTING OF ANY KIND PERFORMED SO THAT WE MAY COLLECT AND REPORT RESULTS TO YOU QUICKLY.

### PHARMACY INFORMATION:

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

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