Hudson Spine and Pain Medicine
281 Broadway, 2nd Floor
New York, NY 10007
Tel – (646) 596 7386
Fax – (646) 360 2739

NEW PATIENT DEMOGRAPHIC FORM

PATIENT

NAME		AGE	SEX
DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS	
EMAIL	CELL PHONE #		

HOME ADDRESS		
CITY	STATE	ZIP
HOME PHONE	WORK PHONE	

PRIMARY PHYSICIAN		PHONE
REFERRING PHYSICIAN		PHONE
EMERGENCY CONTACT	RELATIONSHIP	PHONE

INSURANCE

PRIMARY INSURANCE		
INSURED'S NAME	DATE OF BIRTH	
ID#	GROUP#	COPAY / COINS

SECONDARY INSURANCE		
INSURED'S NAME	DATE OF BIRTH	
ID#	GROUP#	COPAY / COINS

Hudson Spine and Pain Medicine and its associates may use email, SMS text messages, or other means to communicate with you for billing purposes. We promise to keep all communications, and will never share your contact information with marketers. For more information, please see the back of this form.

I hereby authorize Hudson Spine and Pain Medicine to release by mail or electronically, any information needed by my Insurance Carrier to process claims for payment. I also authorize my Insurance Carrier to forward payment(s) for Medical and/or Surgical benefits to the Physician(s), i.e. provider of service Hudson Spine and Pain Medicine. I understand that I am financially responsible for all services rendered to me whether they are or are not covered by my Insurance.

PATIENT'S SIGNATURE	DATE

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Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

PRINT PATIENT NAME	
SIGNATURE	
LEGAL REPRESENTATIVE	DATE

Notice of Telephone and Text Message Communications for Treatment, Payment and Health Care Operations

This notice informs you that when as our patient you provide your telephone number to our practice as a contact number, we or our service provider may contact you by telephone call at the number provided. We may do so for treatment, payment and health care operations purposes. Payment purposes include collecting payment for services owed.

If the telephone number you provide is to a wireless device, we or our service provider may contact you through autodialed telephone calls and text messages at that number. These communications would include, but not be limited to, communications from our service provider Cedar for payment purposes.