GETWELL MED-CARE P.C.

SHAMIM AHMED, MD; *Board Certified Internal Medicine*
SANDYHA SHARMA, MD; *Board Certified Internal Medicine*
EUN SUNG CHOI (CHLOE), NP; *Board Certified Nurse Practitioner*

PATIENT DEMOGRAPHIC FORM

I. Patient Information

*Patient Name (Last, First, M):_____
*Date Of Birth (mm/dd/yyyy): _____ Sex: □ Male □ Female
*Patient's Address : _____
* City: _____*Zip Code: _____
*Patient's Contact Number: _____
*Home #_____ *Work # _____
*Email: _____
*Social Security : _____
*Primary Language:_____
*Employment: □Part Time □Full Time □Retired □Unemployed
*Student: □Part Time □Full Time
*Employer or School Name: _____Phone #: (____)_____
*Emergency Contact Name: _____Phone #: (____)_____
*Relationship to Patient: _____
*Marital Status: □Single □Married □Divorced □Widowed □Legally Separated
*Race : □Asian □American Indian or Alaska Native □ Black or African-American □ White □Unknown
*Ethnicity : □Not Hispanic □ Hispanic
*Pharmacy Name :_____ Phone #: (____)_____

II. Insurance Information

Primary Insurance Company: _____Insured ID:_____
Patients Relation to Insured (check one): □Self □Spouse □Child □Other _____
Secondary Insurance Company: _____Insured ID:_____
Patients Relation to Insured (check one): □Self □Spouse □Child □Other _____
Social Security: _____

IV. Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information to process this claim. I permit a copy of the authorization to be in the place of the original. I hereby authorize Dr. Shamim Ahmed to apply for benefits on my behalf for covered services rendered by his, or by his order. I request that payment from my insurance company be made directly to Dr. Shamim Ahmed. I permit a copy of authorization to use in place of the original. This authorization may be revoked by either me or my insurance company at any time.

V. Patient Consent for Use and Disclosure of Protected health Information.

I have read a copy of GETWELL MEDCARE notice of Privacy Practices. With my consent, GETWELL MEDCARE, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). With my consent, GETWELL MEDCARE may call my home or other designated locations and leave a message on voicemail or in person reference to any items that assist the practice in carrying out (TPO), such as appointment reminders, insurance items and call pertaining to my clinical care, including laboratory results among others. With my consent, GETWELL MEDCARE may mail to my home or other designated location any items that assist the practice to carrying out (TPO), such as appointment reminders cards and patient statements. By signing this form, I am consenting to GETWELL MEDCARE use and disclosure of PHI to carry out TPO. I may revoked my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, GETWELL MEDCARE may decline to provide treatment to me.

DATE: ____ /____ /____ **Signature: _____**

(Patient, Parent or Guardian)

GETWELL MED-CARE P.C.
3530 64th St.
Woodside, NY 11377
Tel: 718-205-6561
Fax: 718-205-4815

Acknowledgement and Consent

HIPAA (Health Insurance Privacy Accountability Act)

Patient's Name: _____ DOB: ___/___/___

By signing below, I acknowledge that I have been provided a copy of Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Dr. Shamim Ahmed and his business associates and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care (referrals), disclosure to school, to seek and receive payment for services given to me, and for the business operations of Dr. Shamim Ahmed and his staff, and the facilities.

_____

Signature of patient or authorized representative

Relationship to Patient: _____ Date: ___/___/___

AFFIRMATION OF PRIOR RECEIPT

By signing below, I acknowledge that I have already received a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. I do not wish to receive another copy of the Notice of Privacy Practices at this time.

_____

Signature of patient or authorized representative

Relationship to Patient: _____ Date: ___/___/___

A professional corporation dedicated to humanity. We care for your good health.