NEIL S. ROSENTHAL, MD, PC
201 EAST 15TH STREET
NEW YORK, NY 10003-3723
TELEPHONE: 212-260-5060

PLEASE PRINT CLEARLY

PATIENT NAME: _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

STREET ADDRESS: _____ APT.#: _____ PRIVATE HOUSE: ____

CITY, STATE & ZIP CODE: _____

HOME: ( )_____ MOBILE ( )_____ WORK: ( )_____

EMAIL: _____

GENDER IDENTITY: ☐ FEMALE ☐ MALE ☐ NON-BINARY / GENDER QUEER

☐ TRANSGENDER FEMALE/ MALE-TO-FEMALE ☐ TRANSGENDER MALE/ FEMALE-TO-MALE

PREFERRED PRONOUN(S): ☐ SHE/HER/HERS ☐ HE/HIM/HIS ☐ THEY/THEM/THEIRS

MARITAL STATUS: ☐ SINGLE ☐ PARTNERED ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

OCCUPATION: _____

EMPLOYMENT STATUS: ____ EMPLOYED ____ SELF-EMPLOYED ____ UNEMPLOYED _____ DISABLED

____ RETIRED ____ PART-TIME STUDENT ____ FULL-TIME STUDENT

EMPLOYER NAME: _____

PRIMARY CARE PHYSICIAN: _____ TELE: ( ) _____

ADDRESS: _____

WHO REFERRED YOU TO DR. ROSENTHAL: _____

IS THE REASON FOR YOUR VISIT THE RESULT OF A WORK OR MOTOR VEHICLE ACCIDENT? YES___ NO___

PHARMACY NAME: _____ STORE #: _____ TELEPHONE: (_____) _____

PHARMACY ADDRESS (include zip code): _____

INSURANCE INFORMATION

PRIMARY INSURANCE

THIS POLICY IS: ____ MY OWN ____ MY SPOUSE'S ____ MY PARENT'S OTHER _____

NAME OF THE INSURANCE COMPANY: _____

COPAYMENT: $_____ CO-INSURANCE: _____ DEDUCTIBLE: $_____

POLICY NUMBER: _____ GROUP NUMBER: _____

IF THIS POLICY IS NOT YOUR OWN POLICY GIVE THE FOLLOWING INFORMATION ON THE SUBSCRIBER:

SUBSCRIBER'S FULL NAME: _____

SUBSCRIBER'S SEX: ____ MALE ____ FEMALE SUBSCRIBER'S BIRTHDATE: _____/_____/_____

SECONDARY INSURANCE

THIS POLICY IS: ____ MY OWN ____ MY SPOUSE'S ____ MY PARENT'S OTHER _____

NAME OF THE INSURANCE COMPANY: _____

COPAYMENT: $_____ CO-INSURANCE: _____ DEDUCTIBLE: $_____

POLICY NUMBER: _____ GROUP NUMBER: _____

IF THIS POLICY IS NOT YOUR OWN POLICY GIVE THE FOLLOWING INFORMATION ON THE SUBSCRIBER:

SUBSCRIBER'S FULL NAME: _____

SUBSCRIBER'S SEX: ____ MALE ____ FEMALE SUBSCRIBER'S BIRTHDATE: _____/_____/_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

FULL NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME/CELL PHONE: ( )_____ WORK PHONE: ( )_____

If for reasons of confidentiality you object to this practice mailing appointment reminder postcards to you, inform the secretary and check this box. ☐

As part of our efforts to establish good and forthright relationships with our patients, and in order to avoid misunderstanding and confusion regarding our payment policies, the staff is trained to consistently inform you of the financial payment policies of this office. For those patients who are not in an insurance plan with which we participate, full payment is required for all services at the time they are rendered. For those patients in an insurance plan with which we participate, applicable co-payments, co-insurance, and/or unsatisfied deductibles will be collected. For those patients with insurance policies that require a referral or prior authorization to ensure coverage for any specific medical service, be aware that it is solely the patient's responsibility to obtain the necessary referrals and/or prior authorizations. In the event that your account must be turned over to a collection agency, which may contact you by cell phone, a one hundred dollar collection fee will be added to your account, and you agree to pay collection costs, including reasonable attorney's fees. Returned checks are subject to a twenty-five dollar fee.

With regard to telemedicine services, I accept that it is my responsibility to determine if my insurance company covers telemedicine services. If it doesn't and I still have Dr Rosenthal perform a telemedicine service for me I accept that I am responsible for paying Dr. Rosenthal directly and in full for this healthcare service. I have been informed that the fee for a telemedicine visit is now $200. (This fee is subject to change annually.)

Any scheduled appointment must be canceled by phone at least 24 hours in advance (you may leave a message on our answering machine). Follow-up visits are subject to a no-show or same-day cancellation charge of $50, and no-show or same day cancellation of in-office tests are subject to a $100 charge.

Your signature below signifies your understanding and acceptance of these policies.

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required to process insurance claims.

This medical practice's "Notice of Privacy Practices" is posted in this office, and I am hereby informed that a copy of it is available upon my request.

_____ _____

PATIENT'S *SIGNATURE (or parent if patient is a minor)* DATE

_____

PRINT PATIENT'S NAME