

651 Old Country Road
Plainview, NY 11803

THE CENTRAL ORTHOPEDIC GROUP, LLP

Phone: (516) 681-8822

Fax: (516) 681-3332

www.centralorthopedicgroup.com

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, The Central Orthopedic Group, LLP, assure that we may contact you by telephone at your home, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as followed (**Please check ALL that apply**)

- At my home telephone number () _____ - _____
- At my work number () _____ - _____
- At my cell number () _____ - _____
- You can leave messages with detailed information
- Leave message with call back number only

In writing at:

- My home address
- My work address
- My fax number () _____ - _____

Other ----- Please specify any other person(s) allowed to contact our office on your behalf:

Signature of Patient

Date

Print Name

Account #

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Policy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Signed _____ Date _____

RELATIONSHIP (if not patient) _____

If patient/patient's representative refuses to sign acknowledgement, please document and date time notice was presented to patient and sign below.

Presented on (date and time) _____

By (name and title) _____

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Seema V. Nambiar, M.D.
Estelle Muscat, RPA-C
Frank J. Smith, RPA-C

DATE OF EXAM: _____ Account number# _____

PATIENT NAME: _____

Responsible Party/ Policy Holder : _____

Insurance Company name: _____ Member Id# _____

How did the occurrence happen?

What part of the body was injured/hurt?

Date of Onset: _____

Address of Onset: _____

Was this related to a Motor Vehicle accident yes / no

Was this a Work related accident yes / no

I affirm that the above statement is true and request the release of any monies from my insurance company to the Central Orthopedic Group, LLC.

I also give permission to the Central Orthopedic Group to release any information necessary to pay this claim to my health insurance company.

PATIENT SIGNATURE: _____ Date: _____

Responsible party Signature: _____ Date: _____