THE CENTRAL ORTHOPEDIC GROUP, LLP

651 Old Country Road
Plainview, NY 11803

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:

_____

_____ Date _____
Signature of Patient

_____ Account # _____
Print Name

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 occurance 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: _____