PATIENT INFORMATION FORM

PATIENT LAST NAME: _____FIRST NAME:_____

SSN:_____DOB:_____SEX:_____

ADRESS:_____APARTMENT_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE NUMBER:(___)_____

MOTHER'S (maiden) NAME:_____DOB:___/___/___WORK #:_____

FATHER'S NAME:_____DOB:___/___/____WORK#_____

PCP:_____ OR REFERRED BY: _____

ADDRESS:_____CITY _____STATE:_____ZIP_____

EMERGENCY CONTACT:_____REL:_____PHONE:(___)_____

BILLING INFORMATION

PRIMARY INSURANCE: _____NAME OF INSURED:_____

SSN:_____DATE OF BIRTH:____/____/____POLICY NUMBER:_____

SECONDARY INSURANCE:_____NAME OF INSURED:_____

SSN:_____DATE OF BIRTH:____/____/____POLICY NUMBER:_____

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original on file. I hereby authorize Dr. Rappaport to apply for benefits on my behalf for covered services rendered to her or by her orders. I request payment to be made directly to Dr. Rappaport. I have read, and accept, Dr. Rappaport's payment policy statement and I understand and agree that, I am ultimately responsible for the balance on my account, for any professional services rendered.

Signature:_____Date:_____

PATIENT CONSENT/HIPPA FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1196 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action on this consent.

Patient Name:_____Signature:_____

Relationship toPatient:_____Date:_____