# Patient Information Form *Please Complete all entries*

Isaac Kramer, MD

| Mr. Mrs. Ms | **Your Last Name** | **First Name** | M. I. | Marital Status M S D | Date of Birth |
|---|---|---|---|---|---|
| | | | | | |

| **Your Preferred Name (NICKNAME)** | Your **email** | |
|---|---|---|
| Street **Address** | **Home** phone number | **Work** phone number |
| City, State, Zip Code | **Cell** phone number | What is the best way to reach you? |
| Your **employer** | Whom may we thank for referring to us | |

**The information below is requested by the government for statistical purposes. If not marked, we will send it as unknown**

| **Your race:** | **Your ethnicity:** | **Pharmacy location (city)** |
|---|---|---|
| ○American Indian or Alaska native<br>○Asian<br>○Black or African American<br>○Native Hawaiian or other Pacific Islander<br>○White<br>○Other<br>○Unknown | ○Hispanic or Latino<br>○Not Hispanic nor Latino<br>○Unknown | |
| | **Language spoken at home:** | Your **MAILORDER** pharmacy |

Your **Pharmacy name** and **phone** number

## Emergency Contact Information

| Your spouse/friend name **(Last, First)** | Phone number |
|---|---|
| Nearest friend NOT living with you | Phone number |

## Insurance information

| Name of the insured (Last, First) | Date of birth of the insured |
|---|---|
| Insurance plan | |

## Consent to disclose Personal Health Information for purposes of treatment and payment.

I understand that **ISAAC KRAMER, MD, P.C.,** its physicians and physician group practices are required to fully document my medical history, current condition, treatment plan and all treatment rendered, including the results of all tests, procedures and therapies. This information is required to be maintained by the organization in a safe and secure way to insure privacy and confidentiality. I understand that the information documented must be available to those involved in my care. Access to my medical record information within the organization is restricted and only available on a Need-to-Know basis. I understand that my health care information, whether stored on paper, computer, film, or other medium is available to ISAAC KRAMER, MD, P.C. physicians and facilities now and in the future on a Need-to-Know basis to health workers involved in my care, teaching, Institutional Review Board approved research, and/or internal utilization management and quality review. I understand that phone calls made to me 24-72 hours prior to the scheduled visit serve as a reminder and would not disclose any clinical information.

I hereby authorize **ISAAC KRAMER, MD** to release my health information requested by any health insurance company related to the claims filed for this visit, or benefit assessment. I also authorize the release of medical information to other hospitals, facilities, physician(s), including referring physician(s), or agencies in order to facilitate my current care following my treatment from **ISAAC KRAMER, MD**, or in the case of medical emergency. All other access is prohibited without my specific written authorization. My signature below constitutes my acknowledgment that I have read and agree with the information provided in this form.

## Insurance billing policy

**I understand that only my primary insurance carrier will be billed. Any balance left after the primary insurance billing becomes my responsibility.**

**I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional *collection fee* of fifty dollars ($50) or 20% of the balance owed, whichever amount is greater.**

Signature:_____ Today's date_____