Cross Bay Medical Services, P.C.
159-05 92 Street
Howard Beach, NY 11414
Phone # 718-835-3636
Fax # 718-835-0897

Date _____
Patient
Last Name_____ First Name _____
Address _____
_____
Phone # _____ Cell # _____

Sex Male Female Single Married Widowed Separated

Employed by _____ Occupation _____
Address _____
Phone # _____ Date of Employment _____
Insurance Co. _____ ID # _____
Social Security # _____ Date of Birth _____
****

Spouse's Name _____
Spouse Employed by _____
Address _____
Phone # _____
Spouse's Insurance Co. _____
Social Security # _____ Date of Birth _____
****

Do you use tobacco now? _____ In the past? _____ Type _____
Daily? _____ How long? _____
Do you use alcoholic beverages? _____ Type _____
Weekly amount _____ How long? _____
Medications _____
_____
Known medical problems _____
Family History _____
Allergies _____
Main complaint or problem _____
Who referred you? _____Email _____

CROSS BAY MEDICAL SERVICES, PC
159-05 92ND Street
Howard Beach, NY 11414
Telephone: (718) 835-3636

Request for Medical Claims Settlement and Assignment of Benefits

I hereby allow and direct _____insurance to make check payable to: Cross Bay Medical Services and remit payment to: Cross Bay Medical Services 159-05 92nd Street, Howard Beach, NY 11414.

Our bill review process involves a review of claims against industry-recognized standards for Usual, Customary & Reasonable (UC&R) pricing and coding standards

I, _____ the undersigned am asking that Cross Bay Medical Services ("Healthcare Provider") agree to accept the adjusted price listed below (less deductible, co-insurance, or co-payment) as the full payment for services rendered to me.

By accepting this adjusted price and agreeing to reduce the liability of the patient and payor, Cross Bay Medical Services agrees not to bill the patient (or financially responsible party) for the difference between the total charges (list price) and the adjusted price. Cross Bay Medical Services maintains the right to bill the patient (or financially responsible party) for items not covered under the patients' policy and deductible, whenever applicable.

A copy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____
Patients Signature Date

_____
Print Name

JAY KRIPALANI, M.D., P.C.
159-05 92ND Street
Howard Beach, NY 11414
Telephone: (718) 835-3636

Request for Medical Claims Settlement and Assignment of Benefits

I hereby allow and direct _____insurance to make check payable to: Jay Kripalani, MD, PC and remit payment to:
Jay Kripalani, MD, PC, 159-05 92nd Street, Howard Beach, NY 11414.

Our bill review process involves a review of claims against industry-recognized standards for Usual, Customary & Reasonable (UC&R) pricing and coding standards

I, _____ the undersigned am asking that Jay Kripalani, MD, PC ("Healthcare Provider") agree to accept the adjusted price listed below (less deductible, co-insurance, or co-payment) as the full payment for services rendered to me.

By accepting this adjusted price and agreeing to reduce the liability of the patient and payor, Jay Kripalani, MD, PC agrees not to bill the patient (or financially responsible party) for the difference between the total charges (list price) and the adjusted price. Jay Kripalani, MD, PC maintains the right to bill the patient (or financially responsible party) for items not covered under the patients' policy and deductible, whenever applicable.

A copy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____
Patients Signature Date

_____
Print Name

Cross Bay Medical Services, P.C.

159-05 92nd Street
Howard Beach, NY, 11414
Tel: 718-835-3636
Fax: 718-835-0897

NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice is provided in two layers: This first layer briefly summarizes how we handle your health information; the second layer is a full copy in greater detail of our privacy policies and procedures and is prominently posted in our waiting room, at our webpage, and copies of which are available and provided to you at our front desk.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information you can later revoke it to stop any future uses and disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of this Notice of Privacy Practices. Then return this acknowledgment of receipt to the receptionist or to the address above.

Signature: _____ Name: _____

Patient's name, if other than signature _____ Date: _____

Cross Bay Medical Services, P.C.

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Missed Appointment Fee Policy

Effective 1/1/2009

Dear Patient:

Effective 1/1/2009, Dr. Kripalani will charge a fee for missed appointments. It is very important to Dr. Kripalani that you understand why this fee is being charged. The office is staffed to accommodate your needs. When you miss your appointment, this overhead still needs to be paid and that is the reason for the fee.

Definition: An appointment is "missed" if a patient does not show and does not call, calls to cancel any appointment with less than four (4) hours notice, or cancels an early morning appointment *after the close of the previous business day.*

Fee: The fee for a missed appointment is **$25.00.**

Payment of Fee: Payment of the missed appointment fee is expected when you come in for your next appointment.

If you have any questions, please leave a message for the Office Manager to call you back at (718) 835-3636.

Patient Signature: _____ Date: ___/___/___

Witness Signature: _____ Date: ___/___/___

Cross Bay Medical Services, P.C.

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Howard Beach, NY, 11414
Tel: 718-835-3636
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IMPORTANT NOTICE
effective immediately

Dear Patient:

Please be advised that we ***DO NOT ACCEPT NO FAULT or WORKERS' COMPENSATION*** insurance.

Should you be involved in an automobile accident or injured at work, please advise our staff prior to being seen by the doctor; otherwise ***YOU WILL BE LIABLE*** for the full charges of your office visit.

You are urged to go to the nearest ***Emergency Room (ER)*** at the time of injury and then follow up with a physician who participates in ***NO FAULT OR WORKERS' COMPENSATION*** insurance. The hospital should advise you of a participating physician.

Dr. Kripalani will continue to treat you for your routine medical matters which are ***NOT*** related to the automobile accident or injury at work.

Should you have any further questions, please contact the front desk at (718) 835-3636.

Patient Signature: _____ **Date:** ____/__ _/____

Witness Signature: _____ **Date:** ____/____/____

RECORDS RELEASE AUTHORIZATION

TO: _____
DOCTOR OR HOSPITAL

_____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Jay Kripalani, M.D.

159-05 92ND STREET
HOWARD BEACH, N. Y. 11414

TELEPHONE (718) 835-3636
FAX (718) 835-0897

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS

AND/OR TREATMENT DURING THE PERIOD FROM _____ TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____
(IF RELATIVE, STATE RELATIONSHIP)

119-P