Medical Associates of Manhattan, P.C.
121 East 60 Street, Suite 9B
New York, NY 10021
Phone: 212-230-1144 / Fax: 212-230-1592

Dov Z. Grant, M.D

Lawrence L. Herman, M.D

Cancellation Policy

As of January 5, 2009, Medical Associates of Manhattan will implement a $45 fee for:

- No-shows for appointments
- Cancellations less than 24-hours before appointment
- Same-day cancellations

We find this policy to be necessary because of the large number of these short-term cancellations and no-shows that we have experienced. There are a limited number of patients that we can see in one day. When we are fully booked, we must defer patients to others days or send them to the emergency room. Thus, no-shows and short-term cancellations prevent other patients from getting a timely appointment. We remind patients about their appointments three days and one day prior to the appointment and we keep an electronic record of these confirmation calls.

The $45 cancellation free is **not** covered by your insurance. Thank you for your cooperation and understanding.

I acknowledge, by my signature below, that I have been told about the cancellation fee.

Credit Card on File Policy

At Medical Associates of Manhattan, PC, we require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. After 30 days from when the insurance company had filed and settled claims, there will be a late fee applied to all unpaid statements. This late fee is applicable to all insurance companies, including Medicare.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted on the account.

I authorize, by my signature below, Medical Associates of Manhattan, PC, to charge the portion of my bill that is my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by M.A.M. PC.

☐ **Amex** ☐ **Visa** ☐ **Master Card** ☐ **Discover**

Credit Card Number _____

Expiration Date ____/____/____

Cardholder Name _____

Billing Address _____

Sign name: _____

Print name: _____

Date: _____

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PLEASE PRINT:

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Social Security # _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Gender: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Black ☐ Asian ☐ Other _____ Language _____

Occupation _____ Employer Name _____ Telephone _____

Referred By _____ Relationship _____

If referred by PCP: Name _____ Telephone _____

Pharmacy: Name _____ Telephone _____

In Case of Emergency Contact:

Name _____ Relationship _____ Telephone _____

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birth date _____ Date of last physical exam _____

What is the reason for your visit? _____

SYMPTOMS Check (✓) symptoms you currently are experiencing or symptoms which are related to the reason for your visit:

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you ever had a mammogram?

_____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you currently have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medication or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and outcome

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications if any

HEALTH HABITS Check (✔) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS Check (✔) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

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HIPPA Privacy Authorization Form

Authorized for Use or Disclosure of Protected Health Information

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____ _____.
2. Authorization for release of PHI covering the period of health care (check one):
   - ☐ a. from (date) _____to (date) _____ OR
   - ☐ b. all, past, present, and future periods.
3. I hereby authorize the release of PHI as follows (check one):
   - ☐ a. my complete health records (including records relating to mental health care, HIV or AIDS, and treatment of alcohol/drug abuse) OR
   - ☐ b. my complete health records *with the exception of the following information* (check appropriate):
     - ☐ Mental Health information
     - ☐HIV or AIDS information
     - ☐Alcohol / Drug abuse treatment
     - ☐Other (please specify): _____
4. In addition to the authorization for release of my PHI described above, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

   Name _____Relationship _____

   Name _____Relationship _____

   Name _____Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I direct.
6. This authorization shall be in force and effect until nine (9) months after my death or until (date & event) _____.
7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any persons or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
8. I understand that my treatment, payment, enrollment, or eligibility of benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient: _____ Date:_____