Meeting House Lane Medical Practice, PC
Patient Registration

Patient Information **Date:**

Patient Name: (Last) (First) (Middle)			Date of Birth:
Social Security Number:	Marital Status: **S M D W**	Driver's License:	Sex: **M F**
Street Address: (City) (State) (Zip)			Phone: Cell Home Work Other
Mailing Address (If different than above) (City) (State) (Zip)			Additional Phone: Cell Home Work Other
Primary Care Physician:		Referring Physician:	
Employer Name:	Address:	Business Phone:	Type of Work:
Emergency Contact:	Relationship:	Phone:	
Race:	Preferred Language:	Religion:	

Guarantor Information (Responsible Party, spouse or parent)

(Last) (First) (Middle)		Relationship to Patient:	Date of Birth:
Street Address: (City) (State) (Zip)			Phone: Cell Home Work Other
Mailing Address (If different than above) (City) (State) (Zip)			Additional Phone: Cell Home Work Other
Social Security Number:		Drivers License:	
Employer Name:	Address:	Business Phone:	Type of Work:

Insurance Information

Primary Insurance Name:	Claims Address:	(City)	(State)	(Zip)	Phone:
Policy Holder (Name):	Policy Number	Group Number:		Policyholder Date of Birth:	

Secondary Insurance Name:	Claims Address:	(City)	(State)	(Zip)	Phone:
Policy Holder (Name):	Policy Number:	Group Number:		Policyholder Date of Birth:	

I hereby authorize Meeting House Lane Medical Practice, PC for treatment and the release of any medical information to the insurance carriers to process claims. I also authorize all payments for medical services to the patient to be assigned to the supplier of services. I understand that I am responsible for all amounts not covered by my insurance company, including deductibles and co-insurance.

X_____

Patient or Responsible Party's Signature **Date**

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Nutrition Services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Nutrition Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Nutrition Services	Services Not Covered	$90 - $160

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Nutrition Services listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Nutrition Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Nutrition Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** Nutrition Services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

MEETING HOUSE LANE
MEDICAL PRACTICE
AFFILIATED WITH SOUTHAMPTON HOSPITAL

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form
Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:
1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating
physician; OR
2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ **Provider Telephone Number:** _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____
Signature of Patient **Date of Signature**

Meeting House Lane Medical Practice, PC

Acknowledgment of receipt of Privacy Notice

Today's Date: _____

I, _____ DOB: _____

(PLEASE PRINT PATIENT NAME\ GUARDIAN NAME) (DATE OF BIRTH)

Acknowledge that I have received a copy of:

Meeting House Lane Medical Practice Privacy Notice

Please check one of the following:

(_☐_) I authorize MHLMP to leave messages regarding appointments, test results, and/or medical treatment.

(_☐_) I authorize MHLMP to leave messages regarding appointments only.

(_☐_) I do NOT authorize MHLMP to leave messages regarding appointments, test results and\or medical treatment.

Disclaimer: MHLMP will still call in the event of a care coordination or billing question.

Please list anyone besides doctors that you allow us to release any medical information to. Under **NY State Law**, substance use, mental health and HIV information are considered confidential. Please put a check mark next to those we are able to discuss this information with.

Name:	Relationship:	Clinical Information	Substance Use	HIV	Mental Health
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

☐ I do not wish to share any information with anyone

Patient/Guardian Signature: _____

MEETING HOUSE LANE MEDICAL PRACTICE, PC
57 Hampton Road – Suite 201
Southampton, NY 11968
Tel: (631) 283-1126
Fax: (631) 259.3183

GUARANTOR AGREEMENT FOR NON-COVERED SERVICES:
(Medical Nutritional Therapy)

Individual's Responsibility for Non-Covered Services:

In consideration of services rendered by _____ to the undersigned patient, the undersigned promises to pay Meeting House Lane Medical Practice, PC any co-payment, co-insurance, deductible or any other charges denied by my health insurance carrier.

In addition, I promise to pay for all services not covered by my health insurance plan provided I am informed of same prior to or after receiving said services.

Date of Visit: _____

_____ **Date:** _____
(Signature of patient)

_____ **Date:** _____
(Witness)

$50 - $190