ESSEN
MEDICAL ASSOCIATES, P.C.

Patient Registration Form

Patient Name | Date of Birth

Home Phone | Work Phone | Marital Status

Street Address | Mailing Address

Social Security Number | Email

Insurance Information

Primary Insurance Address | Phone

Subscriber Name | Subscriber ID | Date of Birth | Group Number

Emergency Contact

Emergency Contact Name | Phone Number

Pharmacy Name | Pharmacy Phone

Assignment of Benefits and Authorization Release

I, the undersigned certify that I have the above coverage and I assign directly to Essen Medical Associates, PC all medical benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission.

Medicare: For any services furnished to me by that physician I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request payment to be made and authorize release of medical information necessary to pay claim. If other insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. de Medicare.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge receipt this day from ESSEN MEDICAL ASSOCIATES, P.C. of a copy of the NOTICE OF PRIVACY PRACTICES of ESSEN MEDICAL ASSOCIATES, P.C.

Beneficiary/Guardian Signature | Date

Received By:

Print Name | Signature of Staff Member

*The completed form is to be placed in the patient's medical record.

ESSEN
MEDICAL ASSOCIATES, P.C.

CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to Essen Medical Associates (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services include access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services. You may also call the Provider's office at 718-583-7736.

Beneficiary Acknowledgment and Authorization

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner at a time can furnish CCM Services to you during a thirty (30)-day period.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Provider's Obligations

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan upon request.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Rights

You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then current thirty (30)-day period of services. You may revoke this agreement verbally by calling 718-583-7736 or in writing (to 2616 Halperin Avenue, Bronx, NY 10461). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary

Signature

Print Name

Date of Birth

Beneficiary's Representative and/or Caregiver (if applicable)

Signature

Print Name