Carmel Medical Care, PC
91 Gleneida Ave; Carmel, NY 10512
P: (845) 228-7000 F: (845) 228-5485
TAX ID # 81-1931257
providers@advancedhealthny.com

Attention All Workers Compensation Patients:

Welcome to Carmel Medical Care, PC and Advanced Health NY. Please be advised that New York State has come out with treatment guidelines for your specific injury type. Your treatment in this office must follow these guidelines. We have carefully developed a treatment plan that allows treatment to be given three (3) times per week, for up to four (4) months if necessary for your injury.

Under these guidelines, you are required to attend at least 75% of your scheduled appointments. You are also required to participate in active care (i.e. rehabilitative exercise program) and make a reasonable effort to return to work. If you do not follow all of these requirements, you will be deemed as being outside the guidelines by the New York State Workers Compensation Board and payment for your treatment will be denied and we will be forced to release you from care.

Please sign below indicating that you have read, understand and will abide by these requirements:

Patient Name: _____

Patient Signature: _____

Date: _____

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Dear Patient:

Welcome to Carmel Medical Care, PC and Advanced Health NY. It is our pleasure to serve your health care needs. This office is a multi-disciplinary medical clinic which employs the talents of medical physicians, physician assistants, physical therapists, chiropractors, massage therapists and physical trainers. During your treatment you will receive care from all members of our team. We work together so our patients receive the most complete and comprehensive treatment available. In order for these treatments to be covered by your insurance, some procedures or modalities may be billed under the physician, the physical therapist and/or the chiropractor, or everything may be billed under one provider. This is dependent on state and federal regulations, insurance company policies and your particular plan.

Our providers are participating in most insurance plans, but not all, so you may have a portion of treatment that will be billed as an out of network provider.

This office uses the American Medical Association's CPT codes for billing all procedures performed in this office. Our fees are either taken directly from the Ingenix custom fee analyzer for this area of the country or are set by your insurance company.

If you have any questions or concerns about any of this, please ask and someone will go over it with you in detail.

I, the undersigned, have read and understand the above information and agree to these terms:

Patient Signature: _____

Date: _____

Patient's Guardian Signature: _____

Date: _____

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Confidential Patient Information

How did you hear about our office: _____

Patient Name: _____ Social Security #:_____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Wok Phone: _____ Marital Status: _____

Occupation: _____ Employer: _____

E-mail: _____Nearest living relative & Phone # _____

Spouse Name: _____ Spouse work #: _____

Preferred Language: _____ Race: □ Native American or Alaskan Native □ Asian □ African American □ Hispanic or Latino □ Native Hawaiian or Pacific Islander □ Not Provided □ White

Smoking Status: □ 1-Current every day smoker □ 2-Current some days smoker □ 3-Former smoker □ 4-Never smoked □ 5-Smoker status unknown □ 9-Unknown if ever smoked

Reason For Treatment: Please Answer All Questions. Insurance Companies Require for Authorization For Treatment.

Main Complaint: _____

Additional Complaints: _____

When Did It Start: _____

What Brought It On: □ Auto Accident □ Work Injury □ Yard Work □ Household Chores □ Sports Injury □ Lifting Something □ A Fall □ Exercising □ Shoveling Snow □ Slept Wrong □ No Specific Reason □ Other Please specify: _____

What Makes It Worse: □ Work □ Sleeping □ Lying Down □ Sitting □ Driving □ Household Chores □ Yard Work □ Lifting □ Exercising □ Walking □ Taking Care Of Children □ Increased Activity □ Other Please Specify: _____

What Makes It Better: □ Sitting □ Lying Down □ Sleeping □ Resting □ Exercise □ Shower □ Heat □ Ice □Increased Activity □ Stretching □ Nothing □ Other Please Specify: _____

(PLEASE TURN OVER)

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Current Medications: _____

Other Doctors You Are Seeing For This Problem: _____

Current Treatments: _____

Have You Had A Similar Condition In The Past? _____ How Long Ago? _____

How Was It Treated: _____

Who Is Your Primary Care Physician? Name _____ Phone: _____

Allergies:_____

Please List Any Major Health Problems:_____

Is This Due To An Auto or Work Related Injury? _____ Has A Claim Been Filed? _____

Health Insurance Co.: _____ Policy_____ Primary Insured: _____

Authorization of Payment: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand and agree that this office will prepare any necessary paperwork to assist me in making collection from the responsible insurance carrier and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt of payment. However, I also understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment for those services in full. I also understand that if I suspend or discontinue my care for any reason, any fees for services rendered are due and payable immediately. I also agree to assist this office in any way necessary, in collecting any payments due for services rendered to me by this office, from the responsible insurance carrier.

Consent to Treatment: I consent to Medical Care, Physical Therapy, Chiropractic, Massage Therapy, Rehabilitations and related services at this facility. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. I also understand, acknowledge and affirm that on a rare occasion these services may lead to a temporary increase in pain or soreness and on an even more rare occasion a more serious injury may occur in patients compromised with certain concomitant disease or illness. This includes the 1 in 1 million to 1 in 40 million chance of cerebral vascular accidents during manipulation or mobilization of the neck, the same probability of this occurring while turning your neck or having your hair washed at a salon. This is generally attributed to an underlying defect in the vertebral or basilar artery.

Treatment of Minors: I, as a parent or guardian of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so.

Waiver and Release: I hereby release, discharge, and acquit this facility, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action or loss of any kind arising from my refusal to accept, receive or allow emergency and/or medical services, included but not limited to ambulance service, EMT, physician or urgent care service.

By signing below, I acknowledge and agree to the above:

Patient Signature: _____ Date: _____

Guardian or Responsible Parties Signature: _____

Guardian or Responsible Parties Social Security #: _____

IRREVOCABLE HEALTHCARE
POWER OF ATTORNEY

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____ County, State of New York, do appoint my healthcare provider Dr. Michael J. Bank (hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principal or Principal's family by any auto insurance, health insurance or third party liability insurance companies which relate to medical treatment provided by Attorney to Principal or Principal's family over to Attorney.
2. Demand and direct any and all auto, health, or liability insurance companies, during the course of Principal's or Principal's family medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney at PO BOX 358; Paramus, NJ 07653.

A photocopy of this Power of Attorney shall be considered as effective and valid as the original.

X_____

Name: _____

Address: _____

City, State Zip: _____

Phone: _____

Subscribed and sworn to before me

on the ____th day of _____, 20___ in Putnam County

_____

Notary Public

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____
to pay by check made out and mailed directly to:

Carmel Medical Care, PC
PO BOX 358
Paramus, NJ 07653
(212) 831-1340

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make the check out in my name and mailed directly to:

PO BOX 358
Paramus, NJ 07653
(212) 831-1340

For the professional expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy 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.

With my signature below, the full deductible or co-payment would be a financial hardship on me.

Date: _____

X _____

Policy Holder: _____

X_____

Claimant (if other than policy holder): _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

Based on the level of difficulty over the past few days, if you would or could do the following activities, circle the best answer. Please answer all questions, the staff will score your answers. Thank You.

CRC Functional Reporting Index Name: _____ Date: _____

Body Part: Neck • Upper Mid Low Back • Shoulder R L • Knee R L • Other: _____

Self Care:

Scale	0 = No Difficulty	1 = Mild Difficulty	2 = Some Difficulty	3 = Very Difficult	4 = Severe Difficulty	5 = Unable
Getting Dressed, Doing Buttons	0	1	2	3	4	5
Put on, take off shoes and socks	0	1	2	3	4	5
Groom, Wash	0	1	2	3	4	5
Driving	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (15 min)	5 (Unable)
Cook, prep food	0	1	2	3	4	5
Total: ___/25	0					

Changing and Maintaining Body Position:

Squat	0	1	2	3	4	5
Get in/out: chair, car, bed, bath	0	1	2	3	4	5
Standing	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (10-30 min)	5 (Unable)
Sitting	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (10-30 min)	5 (Unable)
Sleeping OR	0 (All Night)	1 (6-7 hours)	2 (4-5 hours)	3 (2-3 hours)	4 (1-2 hour)	5 (Unable)
Sleep with Meds	--------	-------	(All Night)	(4-6 hours)	(2-3 hours)	(1-2 hours)
Total: ___/25	0					

Mobility:

Clean house, perform chores	0	1	2	3	4	5
Travel (cab, bus, train, plane)	0	1	2	3	4	5
Walk	0 (No Limit)	1 (One mile)	2 (1 block)	3 (Btw Rooms)	4 (3-5 Steps)	5 (Unable)
Walk Speed	0 (Run/Sprint)	1 (jog)	2 (Fast Walk)	3 (Normal)	4 (Slowly)	5 (Unable)
Stairs Up/Down	0 (No Limit)	1 (30 steps)	2 (20 Steps)	3 (10 steps)	4 (1-3 steps)	5 (Unable)
Total: ___/25	0					

Handling Objects:

Use tools, appliances	0	1	2	3	4	5
Open doors, jars, bottles	0	1	2	3	4	5
Lift Object from floor	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Lift Object Overhead	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Carry bag, box, suitcase	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Total: ___/25	0					

Totals (add up above totals for total score /100, multiply each category x 4 for category score /100):

Total: ___/100	**Self Care = _____/100**	**Position = _____/100**	**Mobility = _____/100**	**Objects = _____/100**

Rating:	**CH: 0**	**CI: 1 to 19**	**CJ: 20 to 39**	**CK: 40 to 59**	**CL: 60 to 79**	**CM: 80 - 99**	**CN: 100**

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Information to be Used or Disclosed:

RELEASE OR OBTAIN ANY AND ALL MEDICAL RECORDS RELATED TO MY MEDICAL CONDITION AND TREATMENT

Purpose of the Disclosure: **COORDINATION OF CARE AND TREATMENT**

May we leave a message on your answering machine? Yes____ No____

Persons Authorized to Use or Disclose This Information:
Carmel Medical Care, Pc; Advanced Health & Injury Care; Advanced Health & Human Performance
Additional Persons to Whom Information May Be Disclosed (include relationship):
_____

Expiration Date of Authorization:
This authorization is effective through _____/_____/_____ or NO Expiration if blank, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. A photocopy of this authorization shall have the same force and effect as an original.

Name of patient

Signature of Patient Date

Carmel Medical Care, PC
91 Gleneida Ave; Carmel, NY 10512
P: (845) 228-7000 F: (845) 228-5485

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES*

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Carmel Medical Care, PC Notice of Privacy Practices*. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices*.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

*A copy of our Privacy Practices is available on our website: www.advancedhealthny.com, posted in our office or upon request.