LexPark Medical Care, PLLC
120 E. 79th Street, Suite 1A
New York, NY 10075
Phone # 212-861-0400
Fax # 212-327-1950

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: _____

Spouses's 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: _____

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Request for Medical Claims Settlement & Assignment of Benefits

I hereby allow and direct _____Insurance to make check payable to : LexPark Medical Care, PLLC , and remit payment to: 120 E. 79th Street, Suite 1A, New York, NY 10075

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 LexPark Medical Care, PLLC (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 payer, LexPark Medical Care, PLLC agrees not to bill the patient (or financially responsible party) for the difference between the total charges (list price) and the adjusted price. LexPark Medical Care, PLLC 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.

_____

Patient Name (print) Date

_____

Patient Signature

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Missed Appointment Fee Policy
Effective 08/01/2022

Dear Patient:

Effective 08/01/2022 Dr. Kripalani will charge a fee for missed appointments. It is very important for 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 this 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 cancel 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 212-861-0400.

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

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As a result of the Health Insurance Portability and Accountability Act (HIPAA) enforced by the US Department of Health and Human Services Office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Lexpark Medical Care, PLLC to send/give my medical information as noted:

Leave a voice mail recording including my personal health information on my home/cell phone	Yes	No
Leave a voicemail recording including my personal health information on my business phone	Yes	No
Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results	Yes	No
Speak to a family member of my choosing (Personal Representative) regarding my personal health information	Yes	No

Name of Personal Representative: _____

On his date _____, I have received and reviewed Lexpark Medical Care, PLLC's Notice of Privacy, which describes how medical information may be used and disclosed and explains how I can get access to this information.

By signing below, I acknowledge that I have had an opportunity to raise questions regarding this Policy and all of my questions have been answered.

The authorization made above will remain effective until such time as I notify Lexpark Medical Care, PLLC by certified mail at the above address of requested changes.

_____ _____
Patient Signature Date

_____ _____
Social Security Number Date of Birth

_____
Patient Phone Number

LexPark Medical Care, PLLC
120 E. 79th Street, Suite 1A
New York, NY 10075
Tel# 212-861-0400
Fax# 212-327-1950

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for LexPark Medical Care, PLLC to access my pharmacy benefits data electronically through Doctor First. This consent will enable Jay Kripalani, M.D. of LexPark Medical Care, PLLC:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about **ALL** other prescriptions prescribed by other providers using DoctorFirst.

_____
Patient Name (Print)

_____

_____
Patient Signature Date

Jay Kripalani MD, PC
209 Glen Cove Rd., Suite 101
Carle Place, NY 11514
Phone # 212-861-0400
Fax # 212-327-1950

Request for Medical Claims Settlement & Assignment of Benefits

I hereby allow and direct _____Insurance to make check payable to : Jay Kripalani MD, PC , and remit payment to: 209 Glen Cove Road, Suite 101, Carle Place, NY 11514.

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 payer, 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 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.

_____

Patient Name (print) Date

_____

Patient Signature

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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 (212) 861-0400.

Patient Signature:_____ Date: _____

Witness Signature:_____Date:_____

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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: _____