Daniel J. Nadler, MD
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Suite 102
Sewickley, PA 15143
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Suite 202
Beaver, PA 15009
(724) 774-5920

PATIENT HISTORY: **EMAIL:**

Name: Last First MI			**Primary Phone:** ( ) **Secondary Phone:** ( )		
Street Address:			**City:**	**State:**	**Zip:**
Date of Birth:	**Social Security #**		**Sex:** **M F**	**Primary Care Physician:**	
Marital Status: **S M D W**	**Spouse/Nearest Relative**		**Guarantor:**	**Referred By:**	

EMPLOYMENT INFORMATION:

Employers Name _____ Phone# _____
Address _____ Occupation _____
City _____ State _____ Zip _____

INSURANCE INFORMATION:

Do you have medical insurance? _____ Yes _____ No

Primary Insurance _____ Secondary Insurance _____
Occupation _____ Occupation _____
Policy Holder Name _____ Policy Holder Name _____
Date of Birth _____ Date of Birth _____
Group # _____ID#_____ Group # _____ID#_____

ADDITIONAL INSURANCE (VISION OR MEDICAL) INFORMATION:

Insurance Company Name _____ Policy Holder _____
Date of Birth _____
Address _____ Group # _____ ID # _____
_____ Phone # (_____) _____

AUTHORIZATION/PAYMENT:

I request that payment of authorized insurance benefits be made either to me or on my behalf to:

Daniel J. Nadler, MD PC

for any service furnished to me by that physician or supplier. I authorize any holder of medical information about myself to release to the insurance and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for any coinsurance, copayments, deductibles, or any services that are not covered by my insurance.

Signature: _____ Date: _____

(OVER)

FINANCIAL POLICY:
All payments are expected at the time of service and any outstanding balances are due within 30 days unless prior arrangements have been made with the Billing Department. All balances that reach 90 days past due may be sent to a collection agency. You would be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service.

_____ _____

Signature of patient and/or guarantor **Date**

NOTICE OF PRIVACY POLICIES ACKNOWLEDGEMENT
I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Policies* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Policies.* I understand that this office has the right to change its *Notice of Privacy Policies* from time to time and that I may contact Daniel J. Nadler's office at any time to obtain a current copy of the *Notice of Privacy Policies*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ **Date:** _____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Policies Acknowledgement* but was unable to do so as documented below:

Date: _____ **Initials** _____ **Reason** _____

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