DAVID S. FELDMAN, M.D.
Chief, Pediatric Orthopedic Surgery
Professor of Orthopedic Surgery
NYU Langone Medical Center & NYU Hospital for Joint Diseases

PLEASE PRINT

Patient Last Name	Patient First Name		
Patient Social Security #	Date of Birth	Gender M ☐ F ☐	
Street Address	City	State	Zip
Home Phone	Alternate Phone		
Email	Preferred Contact Method ☐ Home ☐ Alt Phone ☐ Email		
Parent 1 Name Gender M ☐ F ☐	Parent 2 Name Gender M ☐ F ☐		
Parent 1 Social Security #	Parent 2 Social Security #		
Parent 1 Employer	Parent 2 Employer		
Parent 1 Work Address	Parent 2 Work Address		
Parent 1 Work Phone	Parent 2 Work Phone		
Parent 1 Occupation	Parent 2 Occupation		
Pediatrician's Name	Pediatrician's Phone Number		
Pediatrician's Street Address	City	State	Zip
How Did You Hear About Us?			

IMPORTANT!! Please complete the section below for each insurance that you have. Please have your insurance card ready for us to copy.

PRIMARY INSURANCE

Is this claim a result of an auto accident? Yes ☐ No ☐		Accident Date	
Insurance Company	Policy ID Number	Group Number	Insurance Company Phone Number
Insurance Street Address	City	State	Zip
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Gender	Policy Holder Relation to Patient

SECONDARY INSURANCE

Insurance Company	Policy ID Number	Group Number	Insurance Company Phone Number
Insurance Street Address	City	State	Zip
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Gender	Policy Holder Relation to Patient

RELEASE

I authorize this office to release any medical information pertaining to medical history and/or information necessary to expedite insurance claims, and request direct payment of benefits to the above provider. I understand that I am responsible for all deductibles, pays, and cost shares as determined by my insurance coverage. Patient, Parent or

Parent / Guardian Signature _____ Date_____

67 Irving Place North, 8th Floor / New York, NY 10003
Tel: (212) 533-5310 / Fax: (212) 533-5345 / Email: admin@davidsfeldmanmd.com

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Patient Name:

Date of Birth:

Date of Service:

WELCOME TO OUR PRACTICE

We take pride in our commitment to quality and patient care. Dr. Feldman and his staff are dedicated to helping you with your Orthopaedic problems. This document serves an important function. It informs you of specific rights you have as a patient, as well as responsibilities concerning your insurance and other financial commitments.

Notice of Privacy: Our office is committed to providing maximum protection of your private medical records. Access to your medical records is restricted to the office staff for medical and office related functions. By signing this agreement, you agree to the release of medical information obtained during the course of this and future examinations for medical purposes. This includes copies of your medical records sent to your personal physician, referral physician, and any other health care providers you entered on this form through standard and electronic means. Additionally, you agree to allow us to release medical information with your insurance carrier in any situation that we feel is necessary in your best interests.

My Personal Physician Is:

The Doctor Who Referred Me:

Notice of Financial Obligations: Your office visit today generates a bill for services rendered. It is your responsibility to pay for or arrange for the payment of all services rendered during the course of this office visit. Your insurance company may pay for all or part of the bill. It is your responsibility to know what benefits are specifically covered by your insurance company. If Dr. Feldman is a participating physician with your insurance company please be aware that your specific plan may or may not cover all service rendered. All services not paid for by your insurance company are considered "non-covered benefits" and they are solely your responsibility. If your insurance company requires referrals or preauthorization from your personal physician or other specific requirements, it is your responsibility to know these rules and obtain all proper referrals and documentation necessary for payment. If you do not adhere to your insurance plans requirements, which result in non-payment of fees to Dr David S. Feldman, M.D. or reduced payment, you understand that you are responsible to pay the full amount of the bill. You are responsible to pay for all services that your insurance company deems as "not medically necessary," "non-covered benefits," "included as part of other services rendered," or "not cleared by insurance company to be done by Dr. David S. Feldman, M.D." This includes but is not restricted to: the fee for today's consult whether or not any type of procedure was performed, all x-ray, injections, injectable products, cast materials, and durable medical equipment. If you are a member of Medicare, you are responsible for all financial obligations of that program, which include your yearly deductible as well as the legal allowable charges above the medical reimbursement by Medicare, which may be as high as 20% above Medicare fees.

I have received, read, and understood the above information and agree to all the provisions.

I have reviewed the "NOTICE OF PRIVACY PRACTICES" and agree with its provisions.

Parent / Guardian Signature Date

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