

Name:

DOB:

Adult New Patient Intake Form

Patient Information

Last Name: EPSTEIN First Name: JEFFREY DOB: [REDACTED]
 Gender: M Home Phone: [REDACTED] Mobile Phone: [REDACTED]
 Preferred Phone: (Home) or Mobile (circle one) Email: jeevacation@gmail.com
 Emergency Contact: KARYNA SHULIAK Relationship: FRIEND
 Emergency Contact Phor [REDACTED] Patient Marital Status: S
 Occupation: BANKER Employer: SOUTHERN TRUST
 Primary Care Provider (PCP): DR. BRUCE MOSKOWITZ PCP Phone: [REDACTED]
 Referring Provider: DR. MOSKOWITZ Referring Phor [REDACTED]
 Preferred Pharmacy: VITAHEALTH Pharm Phone: [REDACTED]
 Preferred Pharmacy Address: 1235 1ST AVE

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: DR. SHIMONY Specialty: CARDIOLOGIST
 Doctor's Name: _____ Specialty: _____
 Doctor's Name: _____ Specialty: _____
 Doctor's Name: _____ Specialty: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
 Decline Response
 Hispanic or Latino
 Not Hispanic or Latino

Race:
 Decline Response
 American-Indian or Alaska Native
 Asian

Black or African American
 Native Hawaiian or Pacific Islander
 White
 Other

Preferred Language: Decline Response

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).
 Received N/A (only if you received the notice from ColumbiaDoctors previously)

Information Disclosure and Consent

ColumbiaDoctors will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): JEFFREY EPSTEIN
 Patient or Legal Guardian Signature: [Signature] Date: MAY 18, 2017

*Please refer to our website: columbiadoctors.org, for a list of insurances accepted by your provider.