Shulamit Lerner, MD
Healthy Horizons Pediatric Endocrinology
600 West 246th Street, 104A, Riverdale, Bronx, NY 10471
Tel: 718-432-8800 Fax: 855-874-7381

PATIENT INFORMATION

Last Name_____ First Name: _____ Middle Name: _____

Birthdate: _____ Legal Sex: M / F / O Gender M / F / O Language _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Contact Telephone Number:_ _____

1. PARENT INFORMATION

Name _____ Legal Sex: M/F/O Gender M/F/O

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Contact # _____Secondary Contact #_____

Email _____

2. PARENT INFORMATION

Name _____ Legal Sex: M/F/O Gender M/F/O

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Contact # _____Secondary Contact #_____

Email _____

RACE/ETHNICITY/LANGUAGE: (IT IS MANDATED TO ASK, BUT NOT TO RESPOND)

Race: _____ Hispanic/Latino _____ Non-Hispanic or Latino _____ Unreported

Ethnicity _____ American Indian or Alaska Native _____ Asian _____ Native Hawaiian or other Pacific Islander

_____ White _____ Black/African-American _____ Hispanic _____ Other Race _____ Unreported

Language spoken at home: _____ English _____ Other: _____

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PRIMARY PEDIATRICIAN

Name: _____ Telephone: _____

Address/City/State:_____ Fax Number: _____

INSURANCE INFORMATION – Needed for prior authorizations for medications and imaging.

PRIMARY INSURANCE INFORMATION

Name of Policy Holder _____ Relationship to patient_____

Birthdate _____ Legal Sex: M / F / O

Insurance carrier name _____ Policy number_____

Please send images of both the front and back of each insurance and pharmacy card with this form.

SECONDARY INSURANCE INFORMATION

Name of Policy Holder _____ Relationship to patient_____

Birthdate _____ Legal Sex: M / F / O

Insurance carrier name _____ Policy number_____

PREFERRED GENERAL PHARMACY

Name _____ Address_____

SPECIALTY PHARMACY stipulated by your insurance carrier (eg, Accredo, CVS Caremark)

Name _____ Address_____

PHARMACY CARD INFORMATION, as on insurance card, or on a separate card:

Name of Policy Holder _____ Relationship to patient_____

Birthdate _____ Legal Sex: M / F

Insurance carrier name _____ Policy number_____

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PAYMENT POLICY

Dr. Lerner is committed to providing quality, comprehensive, personalized care to her patients and their families. This involves longer appointments with her than most other physicians, with two hours allotted for an initial consultation, and one hour for a follow-up visit.

A "Superbill" can be provided to families following every visit with Dr. Lerner, which can be submitted to insurance companies for reimbursement of out-of-network payments.

A physician's out-of-network status historically has not impacted costs to families for prescription medication or blood tests. Please check with your insurance company for their current policies.
Dr. Lerner recommends you use in-network formularies and facilities, pharmacies, and laboratories for insurance to pay directly for these covered services.

- Initial Consultation fee is $500.
- Follow-up appointment fee is $300.

Included in these visit fees are clarifications of Dr. Lerner's recommendations, a report to the child's physician, and emails informing families of outstanding normal/expected results.

Not included in visit fees are:
- Discussions of the results of blood tests and imaging ordered at a visit, with Dr. Lerner's detailed interpretation and recommendations. This care is prorated at $300/hour.
- To review a new or confirmed diagnosis, and for comprehensive teaching and counseling to appropriately review results, a visit/televisit will need to be scheduled, with a follow-up fee schedule.
- If a prior authorization submission requires more than 30 minutes of coordination of insurance benefits, a letter of medical necessity, or an appeal of a denial by insurance, there will be a $300 fee.

As a service to Dr. Lerner's patients, reminders are sent one week and three days prior to the appointment, by email and by text. However, these are designed as a convenience to you, and their absence does not preclude your timely cancellation if you are unable to attend the visit.
- There will be a $100 fee charged for cancellations within two business days of a scheduled visit.
- Families will be charged the full fee of the scheduled appointment for any same-day cancellation, or failing to show for a scheduled appointment.
- This fee must be paid prior to scheduling any further appointment.

Payment to Dr. Lerner is expected prior to each visit.
- If it was not paid prior to the visit, Dr. Lerner will assist you in paying at the start of the appointment.
- A credit card on file will be kept, with payment at the visit/time of service.
- Cash, debit/HSA cards, Visa and Mastercard and AMEX are accepted.

_____ I understand and agree to the policy above.

Patient/Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

Please circle: SELF / PARENT / GUARDIAN

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PLEASE READ, INITIAL, AND SIGN

PRESCRIPTION HISTORY PROGRAM

_____ I authorize Dr. Lerner to obtain my/my child's medication history.

MANNER OF RECEIVING PAPERWORK

This signature grants permission for Dr. Lerner to send documents to the email address you provided above. Documents include results of and requisitions for labwork and imaging.
Please be advised that while Dr. Lerner's email address is considered secure and HIPAA compliant, it does not guarantee the security of my or my child's medical information if my email is not similarly secured.

_____ I choose to receive paperwork via email

_____ I choose to receive paperwork via fax or mail only

TELEHEALTH POLICY

Telehealth allows for health care when a physical examination by Dr. Lerner is not critical, as in a consultation following another physician's evaluation and examination, or following a recent visit to Dr. Lerner.
According to laws governing medical practice, families must affirm, at each telehealth visit, that they are physically within New York or Florida, states in which Dr. Lerner is licensed to practice medicine. Dr. Lerner will ask you if you are in New York or Florida at the time of each televisit, and will be able to proceed with the planned meeting only if you confirm that you are present in either of those states

_____ I understand that I will need to confirm I am in New York or Florida at each telehealth visit

RECEIPT OF HIPAA OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information.
Shulamit Lerner MD/Healthy Horizons Pediatric Endocrinology is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our practice, its medical staff and affiliated health care providers that jointly perform payment activities and business operations with our practice. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

_____ I have received the Notice of Privacy Practices as is required by State and Federal Regulations.
(see next page)

ATTESTATION OF ACCURACY OF REGISTRATION INFORMATION (PLEASE INITIAL BOTH)

_____ The above information is true to the best of my knowledge.

_____ A copy of this signature is to be used in place of the original

Patient/Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

Please circle: SELF / PARENT / GUARDIAN

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Notice Of Privacy Practices

Dr. Lerner must tell you how she uses, shares, and protects your health information.
Your Health Information is Private. Dr. Lerner is required to keep your information private, share your information only when we need to, and follow the privacy practices in this notice. She must make special efforts to protect the names of people who get HIV/AIDS or drug and alcohol services.
She is required to notify you should a breach of your information occur.

When you registered, you may have provided her with information about your health.
She must share your health information when:

- You or your representative requests your health information.
- Government agencies request information as allowed by law, such as audits.
- The law requires Dr. Lerner to share your information to make sure you receive quality health care and that all the laws have been followed.

Dr. Lerner may review your health information:

- To determine whether you received the correct medical procedure or health care equipment.
- To contact you about important medical information or changes in your health benefits.

Dr. Lerner may also use and share your health information under limited circumstances to:

- Study health care to look at the health information of many consumers to find ways to provide better health care.
- Prevent or respond to serious health or safety problems for you or your community as allowed by federal and state law.
- Dr. Lerner must have your written permission to use or share your health information for any purpose not mentioned in this notice.

What Are Your Rights?
You or your representative have the right to:

- Get a paper copy of this notice,
- See or get a copy of your health information. If your request is denied, you have the right to review the denial,
- Ask to change your health information.
- Ask to limit how Dr. Lerner uses and shares your information. She will look at all requests, but does not have to agree to do what you ask.
- Ask Dr. Lerner to contact you regarding your health information in different ways (for example, you can ask her to send your mail to a different address).
- Ask for special forms that you sign permitting her to share your health information with whomever you choose. You can take back your permission at any time, as long as the information has not already been shared.
- Get a list of those who received your health information. This list will not include health information requested by you or your representative, information used to operate insurance programs or information given out for law enforcement purposes.

For more privacy information, to make a request or to report a privacy problem/complaint, please contact:
The Office for Civil Rights, Department of Health and Human Services Jacob Javits Federal Building,
26 Federal Plaza, Suite 3312, New York, New York 10278
(Telephone) (212) 264-3313 or 1-800-368-1019, (Fax) (212) 264-3039 or (TDD) (212) 264-2355.