Shulamit Lerner, MD
Healthy Horizons Pediatric Endocrinology
3220 Fairfield Avenue, Ground Floor, Right Entrance, Bronx, NY 10463
Tel: 718-432-8800 Fax: 855-874-7381

REGISTRATION FORM

PATIENT INFORMATION

Last Name_______________________________ First Name: _____________________________Middle Name: _________________

Birthdate: _____________________________ Sex: M / F /TG Language spoken______________________________

Address: ____

City: _________________________________ State: ____________________________ Zip: __________________________

Best Contact Telephone Number:____

1. PARENT INFORMATION

Name ____Sex: M / F / TG Birthdate __________________________

Address: ____

City: _________________________________ State: ____________________________ Zip: __________________________

Home # ____ Email

____

Cell #____ Work # ____

Occupation ____ Employer ____

Marital status: Single___ Married___ Divorced___ Spouse's name ____

2. PARENT INFORMATION

Name ____Sex: M / F / TG Birthdate __________________________

Address: ____

City: _________________________________ State: ____________________________ Zip: __________________________

Home # ____ Email

____

Cell #____ Work # ____

Occupation ____ Employer ____

Marital status: Single___ Married___ Divorced___ Spouse's name ____

OTHER ADULTS IN HOUSEHOLD (over 18 years)

Name ____Relationship_________________________Age ___________

Name ____Relationship_________________________Age ___________

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PREFERRED PHARMACY

Name ____________________ Address ____________________

SPECIAL PHARMACY

Name ____________________ Address ____________________

INSURANCE INFORMATION

PLEASE SKIP AND GIVE CARD TO DESK. ONLY FILL IF UNAVAILABLE/NEED TO EMAIL

PRIMARY INSURANCE INFORMATION

Name of Policy Holder ____________________ Relationship to patient ____________________

Birthdate ____________________ SSN ____________________ Sex: M / F /TG

Insurance carrier name ____________________ Policy number ____________________

Employer's name ____________________ Group number ____________________

Employer's address ____________________

City ____________________ State __________ Zip __________

Employer's phone ____________________

SECONDARY INSURANCE (IF ANY)

Name of Policy Holder ____________________ Relationship to patient ____________________

Birthdate ____________________ SSN ____________________ Sex: M / F /TG

Insurance carrier name ____________________ Policy number ____________________

Employer's name ____________________ Group number ____________________

Employer's address ____________________

City ____________________ State __________ Zip __________

Employer's phone ____________________

PRIMARY PEDIATRICIAN

Name: ____________________

City/State: ____________________

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PHARMACY CARD INFORMATION, if separate from insurance card:

Name of Policy Holder ____ Relationship to patient___________________________

Birthdate ___________________________ SSN __________________________ Sex: M / F /TG

Insurance carrier name _______________________________________ Policy number __________________________________

Employer's name ____ Group number __________________________________

Employer's address ____

City _________________________________ State ________________ Zip ______________

Employer's phone ____

The following information is mandated to ask of patients by federal law. Please complete as appropriate.

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

_________ Other Pacific Islander

_________ Unreported

Language spoken at home:

_________ English

_________ Other, Please specify: ____

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PLEASE READ AND INITIAL ALL LINES; SIGN BELOW

_________The above information is true to the best of my knowledge.

_________I authorize my insurance benefits be paid directly to the physician.

_________I understand that I am financially responsible for any charges not covered by my insurance carrier.

_________I authorize my medical provider or insurance company to release any information required to process my claims.

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

Patient/Parent/Guardian Signature____ Date____________________________________

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.

Please review it carefully.

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.

Patient/Parent/Guardian Signature____ Date____________________________________

PRESCRIPTION HISTORY PROGRAM

_______ I authorize Shulamit Lerner MD/Healthy Horizons Pediatric Endocrinology to obtain my child's medication history.

Patient/Parent/Guardian Signature____ Date____________________________________

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______________________, 2023

Patient Name: ____

Pt Date of Birth: ________/______/________

This is a formal document permitting Dr. Lerner's office to send documents to the email address you have already provided for the patient portal. These documents include those Dr. Lerner is unable to send through the secure patient portal, including 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

Signature: _______________________________________

Printed Name: _______________________________________

Please circle: SELF / PARENT / GUARDIAN

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Please read the following and sign below.

1. My scheduled appointment is a commitment between Dr. Lerner and me/my family member to permit timely and appropriate decision-making for my child. These time slots are designed to be sufficiently long to allow time for comprehensive questions to review your child's health, and for conversation to review and answer your concerns. As a result of a scheduled appointment that is longer than is typical for a physician, there are only a few available daily that are either early in the day, or after-school hours, that minimize interference with the school or work day.
2. It causes both an inconvenience to me and to my other patients when there are last-minute cancellations or no-shows, as that time could have been used appropriately had timely notice been given. Moreover, as I arrange for any urgent consultation or revisit during hours usually designated for general office duties and paperwork, it is a significant inconvenience to me as well as my patients requiring my time for these specified services when there are cancelations shortly prior to, or when patients do not show for their appointment.
3. Due to ongoing last-minute cancellations and no-shows, I have instituted a $50 fee for appointments canceled within 2 business days, and $100 for cancellation within 24 hours or a no-show. This fee must be paid prior to scheduling any appointment.
4. As a service to my patients, reminders are sent a week and three days in advance of 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 will be unable to attend the visit.
5. Lastly, should a family arrive more than 15 minutes late for any appointment, I reserve the right to cancel the appointment to reschedule for a time that permits a full appointment.

_____ I understand and agree to the policy above.

Signature: ____

Printed Name: ____

Please circle: SELF / PARENT / GUARDIAN