GOAL Family Medical P.C.

Compassion. Dedication. Trust.

PATIENT INFORMATION

Name: _____ D.O.B: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Home Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

Current gender identity: (Check **ALL** that apply) ☐ Male ☐ Female ☐ Transgender Male

☐ Transgender Female ☐Additional category (Please specify) : _____

Sex assigned at birth: (Check one) ☐ Male ☐ Female ☐ Other: _____

Preferred pronoun: (Check all that apply) ☐ She/her/hers ☐ He/him/his

☐ They/them/theirs ☐ Other (Please specify): _____

PARENTS/LEGAL GUARDIANS INFORMATION

(Please complete if patient is under 18 years old)

Parent's Name: _____ D.O.B _____

Parent's Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Relationship to Patient: _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone: _____

Pharmacy Address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Member I.D #: _____

Relationship to Patient: _____

Secondary Insurance Name: _____ Member I.D#: _____

Relationship to Patient: _____

HOW DID YOU HEAR ABOUT THE PRACTICE? _____

444 MERRICK ROAD. SUITE LL3
LYNBROOK NY 11563
TEL: 516 758 7339 FAX: 516 758 7340
www.goalfamilymedical.com

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PATIENT CONSENT FORM

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your healthcare information.

CONSENT TO TREATMENT

I, with my signature authorize GOAL Family Medical P.C and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health care to provide treatment to me in accordance with the information, explanations and recommendations they provide me.

CONSENT RELATED TO PRIVACY NOTICE

I have had a chance to review GOAL Family Medical P.C.'s Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand that I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restriction. If it does agree to my restriction on PHI use, it is bound by that agreement

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize GOAL Family Medical P.C. to release information acquired in the course of my medical treatment to my insurance companies to facilitate processing my insurance claims.

CONSENT FOR COMMUNICATION

I choose to receive communications from GOAL Family Medical P.C. by phone calls, mail, text or e-mail at the number or address stated, including but limited to communications about appointment, treatment, and payment. I understand that such email and texts may not be secure and there is a risk that they may be read by a third party.

CONSENT FOR PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing GOAL Family Medical P.C. ("GFM PC") as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form.

By signing below and/or by receiving medical services from GFM P.C., you acknowledge and agree to the established policies and procedures of GFM PC, including but not limited to this form. You may request a copy of the current policies from the Office Staff upon request. These policies may be changed from time to time by GFM PC, without notice.

1. *PROVIDER INSURANCE PARTICIPATION*: The providers at GOAL Family Medical P.C. participate with a significant amount of insurance plans. To avoid unexpected charges, please confirm that your health plan is accepted by your GFM PC provider at the listed address on the last page. Patients are responsible for understanding the provisions, limits, deductibles, co-insurance, copayments, and other requirements of their individual benefit plan(s)

2. *APPOINTMENTS WITH PROVIDERS WHO ARE NOT PARTICIPATING IN YOUR PLAN / NO SURPRISE BILLING*

GFM PC strives to assist you by making available a list of providers that may participate with your insurance plan. If we are aware that you are scheduled with a non-participating provider, we will advise you in advance in compliance with the NYS No Surprise Bill Act. GFM PC will attempt to seek payment from your insurance company to obtain reimbursement for services provided. Patients seeing a non-participating provider will be responsible for copayments or deductibles including out of network deductibles as per their insurance policy. If you receive services that are part of an out of network benefit, your portion of financial responsibility may be higher than the in-network rate. By signing this financial agreement, you are acknowledging that you were advised of the difference.

3. *UNINSURED PATIENTS, THIRD PARTY BILLING AND COVERAGE:*

Please be aware that, except as contractually agreed upon otherwise by GFM PC or as otherwise provided by state or federal law, patients are responsible for ensuring payment for all medical services provided. GFM PC will submit claims to all third-party insurance plans for our patients. GFM PC will accept negotiated payment rates from all participating plans outside of any contracted patient responsibility as payment in full. If your insurance plan requires you to pay a co-payment and/or deductible, you will be required to pay that portion as your patient liability, in full, at the time of service. If payment is not received at time of service, you will be billed.

4. *IDENTIFYING YOUR INSURANCE COVERAGE:*

Please bring your insurance card with you to each visit. On your first visit, please bring two forms of identification, one of which must be a state picture ID. We will make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. GFM PC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. It is your responsibility to ensure that all coordination of benefits between plans are accurate and on record for all insurance policies. Should services not be covered due to lack of insurance coverage or due to Coordination of Benefits not being managed, you will be billed directly for said balances.

5. *LABWORK*:

Throughout the course of your care, GFM PC may send blood and/or specimen samples to a variety of clinical laboratories. If your insurance plan contains restrictions or limitations on lab work, please make that known to our staff before your blood is drawn or sent for processing. Patients will be responsible for the fees incurred at the labs if their insurance does not participate with them. If you have questions about bills received for laboratory charges or insurance coverage available to you, please contact the clinical laboratory in question and /or your insurance carrier.

6. *PATIENTS WITHOUT INSURANCE:*

Uninsured patients have a right to receive a Good Faith Estimate for scheduled services. Estimates will be made available in compliance with regulatory guidance and will be made available on the day of your visit (before services are rendered). Regardless of your insurance status or absence of insurance coverage, you are ultimately responsible for the balance on the account for any services rendered

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7) *CO-PAYMENTS, DEDUCTIBLES AND COINSURANCES:*
Patients are responsible to pay their copayment and/or deductible and any past due balances at the time of service. After each visit and after all applicable insurance claims have been processed, you may be billed for any outstanding balances.

8) *WELLNESS/PREVENTATIVE VISIT:*
GFM PC follows the American Medical Associations coding and documentation guidelines. If you or your child are seen for a wellness or well child visit, and during this routine visit an abnormality is encountered or a preexisting problem is addressed, the appropriate problem-oriented evaluation and management service will be coded in addition to the preventive code. This may result in additional charges, such as copayment. You are responsible for these charges accordingly.

9) *ELECTRONIC MEDICAL RECORD AND STATEMENTS:*
GFM PC has a secure patient portal. You can enroll for paperless billing. You can view and pay your bill online, call the office to make a credit card payment, come into the office to make a payment or mail payment to our office. On our patient portal, you can schedule an appointment or message our providers.
In compliance with the Cure's Act, your test results will be made available to you through the patient portal soon after they have been finalized by the lab and likely before your provider has had a chance to review them. It can be hard to understand the meaning of test results without the input of your provider, so please do not come to conclusions about the results before speaking with your doctor. You are strongly encouraged to schedule a virtual or in person visit to discuss the lab results and any concerns you may have.

10) *BAD DEBT / THIRD PARTY COLLECTION AGENCIES:*
Failure to pay your dues may result in GFM PC referring your delinquent/outstanding balances to a third party collection agency. Should your account be subject to collection proceedings, this may affect your credit rating. Please review all billing statements to ensure that your account remains in good standing.

11) *ACKNOWLEDGEMENT:*
By signing below, each of the undersigned acknowledges that: a) you are aware of GOAL Family Medical, P.C's PATIENT CONSENT FORM b)acknowledgement of receipt of privacy notice c) you agree to pay all charges due (or to become due) to GFM PC for the below Patient's care and treatment. d) You further agree that a photocopy of this form shall be as valid as the original.

Once you have signed this agreement, whether by original, fax or electronic signature, you agree to all the terms and conditions contained herein and the agreement shall be in full force and effect.
(REVISED 4/1/2023)

_____ _____/_____/_____

Signature of Patient Date

_____ _____/_____/_____

Parent/Legal Guardian's Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, (Print Patient's Name) _____

acknowledge and agree that I have received a copy of Goal Family Medical P.C.'s Notice of Privacy Practice. Please ask the receptionist for a copy if there is not one attached to this clipboard.

_____ _____

Patient Signature Date

_____ _____

Parent / Legal Guardian's Signature Date

_____ _____

Print Name of Parent / Guardian Relationship to Patient

For Practice Use ONLY

Patient and or Responsible Party have filled out this form and did receive Goal Family Medical P.C.'s Notice of Privacy Practice.

Name: _____

Signature: _____

Job Title: _____

Date: _____

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Do you have a Healthcare Proxy? (Circle One) YES NO

- If yes, please bring a copy upon your next visit

A **healthcare proxy** is a legal document that allows you to appoint another person as your **proxy** or **agent** to make health care decisions for you if you lose the ability to make decisions yourself.

- If no, would you like to create one? YES NO
- If yes, please ask receptionist for Healthcare Proxy form upon visit

_____ _____

Signature Date

We appreciate you choosing us for your healthcare. Thank you for your understanding and cooperation with our policies. It is our privilege to provide your medical care.

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No Show Policy
Effective: September 27th, 2022

It is the policy of GOAL Family Medical P.C. to monitor and manage appointment no shows. Except for emergency situations at the practice's discretion, missing an appointment without a 24 hour notice will result in a **non-refundable** $25 no show fee. All fees must be paid prior to your next appointment in order to be seen.

_____

Patient Name

_____

Patient's Signature or Guardian's Signature

_____

Date

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PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ D.O.B _____

ALLERGIES: _____

List ALL MEDICATIONS (Please include specific doses)

_____ _____ _____

_____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	Crohn's Disease	High Blood Pressure
Alcoholism	COPD	High Cholesterol
Allergies / Seasonal	Dementia	HIV
Anemia	Depression	Hepatitis
Arrhythmia (Irregular heart beat)	Diabetes Type 1 or 2	Lupus
Arthritis	DVT (Blood Clot)	Pulmonary Embolism
Asthma	GERD (Acid Reflux)	Sleep Apnea
Bipolar	Glaucoma	Seizure Disorder
Bladder Problems	Headaches	Stroke
Cancer: _____	Heart Attack	Ulcerative Colitis

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

Family History: Please list any family medical history if applicable

Relationship to Me: _____ Medical History: _____

Relationship to Me: _____ Medical History: _____

Relationship to Me: _____ Medical History: _____

Relationship to Me: _____ Medical History: _____

_____ _____/_____/_____

Patient Signature / Signature of Parent or Guardian Date

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