Hanna Lesicka, M.D., F.A.A.P., P.C.
217 Calyer Street, Brooklyn, NY 11222

PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME**: _____ **MIDDLE NAME**_____

DATE OF BIRTH: MM __DD_____YY_____ **Gender**: F / M

ADDRESS: _____ _____
street apt

_____ _____ _____
city state zip code

- **PRIMARY CONTACT PHONE NUMBER:** _____
- **EMAIL ADDRESS**: _____
- **LANGUAGE PREFERRED:** _____
- **RACE**: White, Black & African American, American Indian, Chinese, Japanese, Asian Indian, Other: _____
- **ETHNICITY**: Not of Hispanic Latino, Mexican, Puerto Rican, Another Hispanic,
- **MOTHER'S FIRST & LAST NAME: _____ MAIDEN NAME _____**

DOB_____ **CELL PHONE#**_____

ADDRESS : _____

- **FATHER'S FIRST & LAST NAME: _____**

DOB_____ **CELL PHONE#**_____

ADDRESS (if different) _____

- **EMERGENCY CONTACT:** _____
(other than parents) (name) (phone) (relationship)
- **HOW DID YOU HEAR ABOUT US**? _____
- **PRIMARY INSURANCE COVERAGE**: _____ ID# _____
- **FULL NAME OF POLICY HOLDER**: _____ SS#_____
- **SECONDARY INSURANCE**: _____
- **PHARMACY:**_____

I authorize the release of the information necessary to process all medical claims. I request all payments for the medical benefits to be made to HANNA LESICKA, M.D., F.A.A.P., P.C**. If the services are not paid by my insurance, I am responsible for all payments.**

_____ _____ _____
Signature of Insured or Authorized Person Print Name Date

CONSENT FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS

HANNA LESICKA M.D., F.A.A.P., P.C. will use your health care information for the following reasons:

Treatment: We sill use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your cared [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may or may not be necessary in your case.

Payment: We may need to use or disclose information in our health record to obtain reimbursement from you, from your health — insurance carrier, or from another insurer for your services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purposes of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations. Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, health care review activities, and arranging for legal and auditing functions.

I …… do hereby agree to allow any health care information to be used for the purpose of treatment, payment, health care operations

_____ _____

Patient's name Patient's/ Parent's/ Guardian's signature

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 01, 2013

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how certain health information about me may be used and disclosed by **Hanna Lesicka, MD, FAAP, PC phone # 718-349-2442** and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and certain reproductive health information.

_____ _____

Patient's/ Guardian's signature Date

_____ _____

Print Name of Patient or Parent/Guardian Relationship to Patient

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(For internal use – where signature above cannot be obtained)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we make a good faith effort to obtain written acknowledgement of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003 we provide treatment, products or services to the patient. We must make a good faith effort to obtain written acknowledgment when reasonably practicable following an emergency situation. If such signature cannot be obtained we must document our good faith efforts to obtain the acknowledgment and why it was not obtained.

Describe good faith efforts to obtain written acknowledgment:

_____

_____

Name: _____ Witness: _____ Date: _____