ReNew Outpatient Wound Care Center
3923 Fort Hamilton Parkway, Brooklyn, NY 11218
TEL: 718-719-6863 | EMAIL: office@renewcares.com
www.renewwoundcare.com

DATE:

FIRST NAME: LAST NAME:

DATE OF BIRTH: PLACE OF BIRTH:

RACE: ETHNICITY:

LANGUAGE:

MARITAL STATUS: SPOUSE'S NAME:

SOCIAL SECURITY NUMBER:

ADDRESS:

CITY: STATE:

ZIP CODE:

CELL PHONE: HOME PHONE:

EMAIL: REFERRED BY:

EMERGENCY CONTACT: RELATION TO PATIENT:

PHONE:

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EMPLOYMENT INFORMATION

COMPANY NAME: | OCCUPATION:

ADDRESS:

CITY: | STATE:

ZIP CODE: | PHONE NUMBER:

INSURANCE INFORMATION

MEDICARE: | PRIMARY

MEDICAID: | PRIMARY

OTHER: | ID NUMBER:

OTHER: | ID NUMBER:

****IF YOU ARE A SUBSCRIBER TO A PARENT'S OR SPOUSE'S INSURANCE, YOU MUST PROVIDE THEIR INFORMATION FOR BILLING PURPOSES.****

NAME OF POLICY HOLDER: | DATE OF BIRTH:

HEALTHCARE PROXY/ADVANCE DIRECTIVE

NAME: | RELATION TO PATIENT:

PHONE NUMBER:

PRIMARY CARE GIVER

NAME: | RELATION TO PATIENT:

PHONE NUMBER:

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PHARMACY INFORMATION – MUST BE COMPLETED IN FULL

NAME:

ADDRESS:

CITY: STATE:

ZIP CODE:

PHONE NUMBER: FAX NUMBER (IF KNOWN):

ALLERGIES:

ALL PATIENTS TO COMPLETE

At ReNew Outpatient Wound Care Center, we are happy to see you at your convenience.

We will do our best to verify that we accept your insurance. Because this matter may not be resolved in a timely manner, we ask that you be aware of your financial responsibility (deductible, copayments, yearly Medicare deductibles, etc.)

If we do not accept your insurance or your insurance is inactive at the time of your visit, we ask that you be aware that you may receive a bill for your visit.

Thank you!

HOW DID YOU HEAR ABOUT US?

- ☐ DOCTOR
- ☐ NURSING HOME
- ☐ FRIEND
- ☐ FAMILY
- ☐ PUBLICATION
- ☐ SOCIAL MEDIA
- ☐ GOOGLE

SIGN:

DATE:

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HIPPA NOTICE OF PRIVACY PRACTICES

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or any use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members, friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became affective on/or before April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is the only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME: _____

SIGN: _____ DATE: _____