Gramercy Pediatrics
247 3rd Ave Suite 204 New York, NY 10010
420 W 23rd St Suite AGF New York, NY 10011

Patient's name: _____ Birth Date: _____

Age: _____ Sex: M F

Address: _____

Phone (Primary): _____

Phone (Secondary): _____

Email: _____

Insurance Information

(*Please give your ID and insurance card to the receptionist***)**

Is patient covered under both parent's insurance? Yes? No?

Insurance Carrier (circle one): Anthem/Empire Cigna Aetna Self-Pay

Insurance Policy Number: _____ Group Number: _____

Name of Responsible Party: _____ Date of Birth: _____

Address (if other): _____

Phone: _____ Relationship to Patient: _____

HIPAA/Prescription Consent Form

I give Gramercy Pediatrics, LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, to view any past prescription histories, and for health care operations like quality review.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.