Morledge Medical Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M / F Date of Birth: _____ SS#: _____

Street Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Email address: _____

Primary Phone #: _____ work/cell **Pharmacy Name/ #**_____

Work Status: Employed /Unemployed /Self Employed /Student /Retired

Ethnicity: _____ Preferred Language: _____ Race: _____

Emergency Contact

Name: _____ Phone#: _____

Insurance

Insurance Name: _____ Policy ID#: _____

If Patient is NOT, the insured:

Name of insured: _____ Date of Birth: _____

Relationship to Patient: _____ Phone#: _____

Address: _____ APT#: _____ City: _____

State: _____ Zip: _____

Referred By: Internet / Magazine / Patient / Physician Name: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I, the undersigned give my authorization to treat and assign directly to **LOUIS J. MORLEDGE, MD, pLLC**, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible to all approved and covered charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I also authorize **LOUIS J. MORLEDGE, MD, pLLC**, to charge any payment due balance to my credit card as they deem necessary. I understand that it is my responsibility to designate Louis J. Morledge, MD as my primary care physician and/or obtain any referrals necessary to ensure proper coverage. Failure to comply may result in denial by my insurance company and I will therefore be responsible for ALL charges incurred.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Louis J. Morledge, M.D. PLLC. The Notice of Privacy Practices provides information about how Louis J. Morledge, M.D. PLLC may use and disclose my protected health information.

I acknowledge receipt of the Notice of Privacy Practices of Louis J. Morledge, M.D. PLLC.

_____ Date: _____

(patient/parent/conservator/guardian)

I authorize: (Please indicate the name of relatives or friends authorized to obtain any of your medical information.)

_____

_____

ALERTS:

All	Text	Email	Phone
Scheduled Appointments	Text	Email	Phone
Confirmed Appointments	Text	Email	Phone
Follow up visit Alerts	Text	Email	Phone
Administrative Alerts	Text	Email	Phone
Clinical Reminders	Text	Email	Phone
Lab Result Notifications	Text	Email	Phone

FOR LOUIS J. MORLEDGE, M.D. PLLC USE ONLY

Inability To Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

_____

_____

Signature of Louis J. Morledge, M.D. PLLC representative: _____ Date: _____

MORLEDGE
MEDICAL
Internal & Travel Medicine
Louis J. Morledge MD PLLc
Sohee Lee, MD
Betsy Glenday, PA • Melissa Favis, PA
150 East 58th Street, 18th floor, New York, NY 10155
212-583-2830 – office 212-583-0444 – fax
TIN - 20-1219129

Credit Card on File Policy

At Louis J. Morledge, MD PLLC, we require keeping your credit card on file as a convenient method of payment for the portion of the services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $2.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Louis J. Morledge, MD to charge the portion of my bill that is my financial responsibility to the following credit card:

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Account Number _____

Exp. Date _____ CVV (3 digit number on back of card) _____

Cardholder Name _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

SIGNATURE _____ DATE _____

I, the undersigned, authorize and request Louis J. Morledge, MD PLLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Louis J. Morledge, MD PLLC.
This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Louis J. Morledge, MD PLLC in writing and the account must be in good standing.

Louis J. Morledge, M.D., PLLC

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

Patient MRN:

Please Fax signed consents to: **917-829-2096**

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Health System Health Information Exchange ("HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU Langone health providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the HIE. In order for a Care Everywhere Provider to know that information may be available through the HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staffs of NYU Langone Health System and affiliated entities to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization, a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Health System and affiliated entities program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling 877-695-4749. Upon request, your provider will print this list for you from this website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology. To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care". You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box ☑ below:

☐ 1. **I GIVE CONSENT** to ALL of the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access ALL of my electronic health information through the HIE and **I GIVE CONSENT** to ALL employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT** to the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access my electronic health information through the HIE and **I DENY CONSENT** to employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the HIE and HEALTHIX. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Print Name of Patient	Patient's Date of Birth	Date
Signature of Patient or Patient's Legal Representative	Print Name of Legal Representative and Relationship (if applicable)	