DONALD T. LEVINE, M.D., F.A.C.S. 75 NORTH BROADWAY NYACK, NY 10960

DATE: _____

PATIENT INFORMATION

FIRST NAME:	M.I.: LAST NAME:
SEX: MALE: FEMALE:	DATE OF BIRTH:
	RACE:
ADDRESS	
ADDRESS:	
	WORK PHONE:
CELL PHONE:	EMAIL:
REFERRING PHYSICIAN:	FAMILY PHYSICIAN:
EMPLOYMENT INFORMATION:	
	PHONE:
	OCCUPATION:
ADDRESS:	OCCOPATION.
WHO IS RESPONSIBLE FOR YOUR AC	COUNT? (CHECK. IF SELF, IGNORE SECTION)
SPOUSE:PARENT:	
	PHONE:
	PHONE:
PRIMARY INSURANCE:	
	RELATIONSHIP:
	SOCIAL SECURITY #:
ADDRESS:	
ADDRESS:	GROUP #:
FEES AND PAYMENTS:	
PAYMENT MUST BE MADE AT THE T	IME OF VISIT UNLESS PRIOR ARRANGEMENTS WERE MADE. IT IS YOUR
RESPONSIBILITY TO PAY ANY DEDUC	CTIBLE AMOUNT, CO-PAYMENT OR ANY OTHER BALANCE NOT PAID FOR BY
YOUR INSURANCE COMPANY.	
THE SIGNATURE ON FILE IS MY AUTH	HORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS
	YMENT DIRECTLY TO THE PHYSICIAN NAMED OF THE INSURANCE BENEFITS
OTHERWISE PAYABLE TO ME.	
DATIENT SIGNATURE:	DATE
(PARENT OR GUARDIAN IF MINOR)	DATE:
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PATIENT MEDICAL HISTORY

Referred By: Do you have any Facial Plastic or Cosmetic concerns? Y N Describe	Name:			Date:	D.O.B.:		_Ag	e:
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DONALD T. LEVINE, M.D., F.A.C.S. HIPPA NOTICE OF PRIVACY PRACTICES

THIS MUST BE COMPLETED BY PATIENT OR REPRESENTATIVE

Patient Name:		
YES I AM AWARE OF THE HIPPA PRIVACY NOTICE	(Please check)	
I give permission to have information left on my	answering machine. YES	NO
I give permission to send me appointment remin voice telephone calls in addition to email appoint		_
I give permission to release information regarding (Please list family members, friends, doctors)	g myself to:	
I acknowledge receipt of this notice.		
Patient or signature:		
Date:		
If you are signing as the patient's representative,	print your name:	
NOTICE OF PR	IVACY PRACTICE	
I acknowledge that I was provided a copy of the I had the opportunity to read if I so choose) and u	<u>-</u>	and that I have read (or
Patient Name (Print)	 Date	
Parent or Authorized Representative		
Signature		

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that, if you must cancel your appointment, you provide at least two (2) weekdays notice. This will enable another person who is in need of an appointment to be scheduled in that appointment slot. With cancellations made less than two (2) weekdays notice, we are unable to offer that slot to other people.

Appointments which are cancelled with less than two (2) weekdays notification will be subject of a \$50.00 cancellation fee.

Patients who do not show up for their appointment <u>without a call</u> to cancel their appointment will be considered a *no show*.

Patients who no show will be subject to a \$50.00 fee.

My practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No Show policy.

Patient Name (Please Print)	 Date
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