

SCHUSTER AND SCHREIBER, P.A.

RONALD H. SCHUSTER, M.D.

JEFFREY E. SCHREIBER, M.D.

DATE _____

NAME (last, first, middle): _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____

HOME PHONE: (____) _____ WORK PHONE:(____) _____

CELL PHONE: (____) _____ E-MAIL ADDRESS: _____

MARITAL STATUS: M _____ W _____ S _____ D _____ SEP _____

PARENTS (if patient is a child): MOTHER: _____ FATHER: _____

GENDER ID: _____ RACE: _____ AGE: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

WHO IS YOUR PRIMARY CARE? _____ OFFICE # _____

PHARMACY: _____ ADDRESS _____ PHONE: _____

OCCUPATION: _____

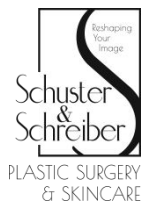
EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT: _____ HOME #: _____

RELATIONSHIP: _____ CELL #: _____ WORK #: _____



Sign to receive our Newsletter & Specials! _____

SCHUSTER AND SCHREIBER, P.A.

RONALD H. SCHUSTER, M.D.

JEFFREY SCHREIBER, M.D.

HIPAA POLICY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Please Print Name: _____

Signature: _____ Date: _____

I GIVE PERMISSION TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING:

_____ mother _____ father _____ spouse

_____ other (specify) _____

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) _____



WAIVER OF LIABILITY:

Your insurance will only pay for services that it determines to be reasonable and necessary. Reasonable effort is made by this office to comply with the guidelines set forth by your insurance company. If your insurance determines that a particular service is not reasonable and necessary under their program standards, your insurance will deny payment for that service. Your insurance may deny payment stating that the service was not medically necessary or that it is cosmetic in nature. Schuster & Schreiber MD PA charges 12% interest on all accounts past 30 days. Should I default in payment, I agree to pay all cost of collections, including collection agency fees, court costs and any reasonable attorney fees up to 35% of the outstanding balance. I authorize Schuster & Schreiber MD PA to apply for benefits on my behalf for services rendered, and request that payment from my insurance company be made directly to Schuster & Schreiber MD PA.

Payment may be denied for the services identified above, for the reason(s) stated. If your insurance denies payment, you agree to be personally and fully responsible for payment.

Patient Signature

Date

Have you ever received a blood transfusion? Y/N If yes, when? _____

Occupation:_____ Do you have children? _____ How many? _____

Do you drink alcohol? Y/N How much? _____

Do use tobacco? Y/N Marijuana? Y/N If yes, how much? _____

Family History of Illness (cancer, diabetes etc.): _____