REGISTRATION DATE: _____
(please print)

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY _____ STATE_____ZIP_____

TELEPHONE (home) _____ (business) _____

Cell_____Email_____

GENDER: M___ F___ Date of Birth:_____
GENDER IDENTITY- how do you see yourself? Male ___Female__
Non-Binary____Other_____
Are you : Hispanic/ Latino Not Hispanic/Latino ___Decline to answer_____
Race: White___ Black/African American____ Am ndian/AlaskanNative___Hawaiian__
Decline_____Preferred Language_____

Marital Status: Single__ Married__ Divorced__ Separated__Widowed__Life
Partner____ Other_____

PHARMACY PHONE AND NAME # _____
EMPLOYER _____

EMERGENCY CONTACT _____

RELATIONSHIP_____TELEPHONE _____

REFERRING PHYSICIAN NAME AND ADDRESS _____
_____TELEPHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER_____
INSURED NAME_____RELATION_____
ID #_____GROUP#_____PLAN#_____
ADDRESS_____TELEPHONE_____

SECONDARY INSURANCE CARRIER_____
PLEASE INCLUDE COPIES FRONT AND BACK

PLEASE SIGN THE APPROPRIATE FORM

ASSIGNMENT OF INSURANCE BENEFITS (COMMERCIAL)

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

I authorize payment of medical benefits directly to Dr. Robert Cooper. I understand that I am financially responsible for all charges incurred.

_____ _____

Signature of Subscriber **Date**

SERVICE FEE FOR NON-CANCELLATION OF OFFICE VISIT

I, _____ am aware that if I have an appointment scheduled with Dr. Cooper and I am unable to keep this appointment, I will be charged a service fee of $25.00 if I do not cancel within 24 hours by PHONE. Email is not for cancelations.

I understand that by not calling to cancel my appointment, I am holding an appointment in the doctor's schedule that could be used for another patient.

Patient or Responsible Party Signature

SERVICE FEE FOR PROCEDURE CANCELLATION

In preparation for a patient scheduling a procedure with our office, our staff performs several steps to make this happen. We prepare the preparation, contact the pharmacy, call the insurance company for authorization and coordinate the schedule with the surgical center. All of these steps require time and staff. In an effort to reduce the number of cancellations we have been getting, we are now keeping a credit card on file.

You may be subject to a cancelation fee of $250.00 if you do not cancel in a timely manner- I week (7 days)

Patient signature

CREDIT CARD AUTHORIZATION FOR MEDICAL SERVICE/ CANCELLATIONS
DR. ROBERT B. COOPER

CC# _____ _____

SECURITY CODE:_____

ZIP CODE _____

EXPIRATION _____

PRESCRIPTION DATABASE CONSENT FORM

I, _____ give Dr. Robert Cooper's office permission to access Surescripts (prescription database) to view my prescription history. As of August 2013, consulting the prescription database is New York State law for providers, Failure to sign this document will restrict Dr. Cooper from prescribing medications to you.

Patient Signature_____

Name: _____ Date: _____
Height :_____ Weight: _____

MEDICAL HISTORY FORM
ALL INFORMATION IS CONFIDENTIAL

1. Why are you coming in to see Dr. Cooper? (current problem or reason for procedure)

_____
_____

2. Medications & Dose:

_____ _____
_____ _____
_____ _____

3. Allergies to Medication (what kind of reaction?):

_____

4. Habits:

Smoking? Former _____ Current_____
How much? How long? _____
Alcohol? (number of drinks per day)
_____

5. Operations: Date:

_____
_____

6. Hospitalizations: Date:

_____
_____

7. Family Medical History of GI conditions or cancer

_____

9. Personal:

Marital status: _____

Number of Children: _____

Current Occupations: _____

Previous Occupation: _____

10. Other Doctors involved in your care: (name, address, phone number, fax number & specialty)

_____

_____

_____

_____

_____

_____

Thank you.

Health Insurance Portability and Accountability Act (HIPAA)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Robert B. Cooper, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Robert B. Cooper, MD's Notice of Privacy Practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Robert B. Cooper, MD reserves the right to revise its Notices of Private Practices at anytime. A revised Notice of Privacy Practices may be obtained by forward a written or email request to Robert B. Cooper, MD's Privacy Office at 635 Madison Ave, 17th Floor, NY 10022.

With this consent Robert B. Cooper, MD may mail to my home or other alternative location and leave a **message** on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including pathology and laboratory results among others.

With this consent Robert B. Cooper, MD may **mail** to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, patient statements and material related to my clinical care.

With this consent, Robert B. Cooper, MD may **e-mail an unencrypted email** to my home or other alternative location any items that assist the practice in carrying TPO such as appointment reminder, patient statements and material pertaining to my clinical care procedure results, among others. I have the right to request that Robert B. Cooper, MD restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Robert B. Cooper, MD's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Robert B. Cooper, MD may decline to provide treatment to me.

Signature of patient _____
Print Name:_____
Date:_____
Email address:_____
(limited to administrative)

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):
Name_____ _____ Relationship _____
Name _____ Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____
Signature of Patient date

NEW YORK STATE SURPRISE BILL LAW

In Compliance with the above New York State Surprise Bill Law, *Effective: March 31, 2015*
Please be advised of the following:
Dr. Cooper does not participate with your medical insurance plan.
You will be registered as a **cash/ private pay patient.** This means that at the time of service you will be paying by cash, check, or credit card. We will submit the claim to your insurance on your behalf so that you can be reimbursed a portion of the bill (if you have out of network benefits).
Dr. Cooper is affiliated with New York Presbyterian- Weill Cornell Hospital (NYP) at 525 East 68th Street, NYC 10065 and Carnegie Hill Endoscopy (CHE) at 1516 Lexington Avenue, NYC 10029.
NYP billing: (212) 746 - 4250
CHE billing: (212) 860 - 6300

York Anesthesia (procedures at Carnegie Hill) - (631) 264-2030
I understand the office of Dr. Cooper is out of network with my insurance plan.
As mandated by the state, I have been advised of the above New York State Surprise Bill.

Procedure Code:	Fee:
Consultation 99244 – 99245	$450.00 – $600.00
Office Visit 99213 – 99215	$350.00 - $450.00
Endoscopy 43239	$1700.00
Colonoscopy 45378 – 45385	$1800.00 - $2200.00
Sigmoidoscopy	$400.00 - $500.00

Patient signature_____

Date_____

THIS FORM ONLY APPLIES IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN OR YOU DO NOT HAVE MEDICAL INSURANCE. IF YOU DO NOT KNOW IF WE ARE IN YOUR PLAN, CALL OUR OFFICE OR YOUR INSURANCE PLAN DIRECTLY FOR VERIFICATION.