neighborhood counseling center
SUPPORT FOR INDIVIDUALS, COUPLES AND FAMILIES

7701 13th Avenue Brooklyn NY
T. (718) 232-1351 F. (718) 837-5676
admin@nccny.com **www.nccny.com**

Neighborhood counseling center complies with medical privacy regulations issued by the u.S. Department of health & human services under the health insurance and portability & accountability act (hipaa) of 1996

PATIENT INFORMATION

Request for Physical Exam made on ___ / ___ / ___ by: _____ Accumed #_____

Patient's Last Name: _____ First: _____ Middle: _____

☐ Mr ☐ Mrs ☐ Miss ☐ Ms. Marital status (tick one): ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

If patient is a minor, name of Parent/Guardian: _____

Social Security No: _____ DOB:___ / ___ / ___ Age: _____ Sex: ☐ Male ☐ Female

Street Address: _____ Apt # _____

City: _____ State:_____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email: _____

Emergency Contact: _____ Relation: _____

Phone: (____) _____

Work Status: ☐ F/T ☐ P/T ☐ Retired ☐ Student ☐ Other _____

Employer/School: _____ Previously a Client: ☐ Yes ☐ No

Who referred you? (Name of Person and/or agency): _____ Phone: (____) _____

Ethnicity (optional): ☐ Non-Latino ☐ Latino Race (optional): ☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaskan Native ☐ Native Hawaiian/other Pacific Islander ☐ other: _____

INSURANCE INFORMATION *Insurance identification cards must be presented at time of registration*

Primary Insurance Company: _____ Insurance ID#: _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insured's Name: _____ DOB: ___ / ___ / ___ Employer: _____

Secondary Insurance Company: _____ Insurance ID#: _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insured's Name: _____ DOB: ___ / ___ / ___ Employer: _____

I authorize Neighborhood Counseling Center to render treatment to myself and/or my dependents/collaterals.

I understand that Neighborhood Counseling Center **staff may contact me and/or leave messages** at the address phone number(s) and/or email address(es) provided above.

I authorize release of information regarding my medical treatment and related information to my health insurance company, their authorized agents and/or intermediaries for the purpose of validating and determining benefits payable.

I authorize payment of medical benefits to the Neighborhood Counseling Center for services I receive. I request payment of government benefits including Medicare and Medicaid to Neighborhood Counseling Center. I authorize photocopies of this form to be as valid as the original. **Charges during a lapse in benefits and deductible periods are the responsibility of the undersigned.** Eligibility must be verified before services are rendered for assigned benefits; ID cards must be presented at registration. All payments are due at time of service.

I understand there is a 24-hour cancellation policy and I will be charged $75.00 for a broken appointment.

My signature below means I understand and agree to the policies and procedures described above.

_____ _____

DATE **SIGNATURE OF PATIENT / PARENT / GUARDIAN / AUTHORIZED REPRESENTATIVE**