PIOTR HUSKOWSKI, M.D.

PLEASE FILL OUT THE FOLLOWING INFORMATION FOR OUR RECORDS. ALL INFORMATION WILL BE KEPT CONFIDENTIAL. THANK YOU.

PROSZE WYPELNIC

PATIENT NAME_____ **DATE OF BIRTH**_____

IMIE I NAZWISKO DATA URODZENIA

ADDRESS_____ **CITY**_____

ADRES MIASTO

STATE___ **ZIP CODE**_____ **PHONE**_____ **CELL**_____

STAN

REFERRING PHYSICIAN_____ **SS NO:**_____

Lekarz Ogolny

RACE GROUP White Hispanic or Latino Non Hispanic or Latino Asian African American American Indian Other Race

PREFERED LANGUAGE_____ **EMAIL ADDRESS:**_____

Podstawowy Jezyk

BLOOD GROUP_____ **MARITAL STATUS** Married Single Divorced Widowed

Grupa Krwi Stan Cywilny

EMERGENCY CONTACT

Kontakt w razie naglego przypadku

Name:_____ DOB_____ Relationship_____

Imie Date Urodzenia Pokrewienstwo

Phone Number_____ Gender_____

INSURANCE COMPANY_____ **POLICY NO**_____

Ubezpieczenie Numer Polisy

SUBSCRIBER DETAILS

Informacje glownego posiadacza ubezpieczenia

NAME_____ **DOB**_____

Imie glownego posiadacza ubezpieczenia Date urodzenia glownego posiadacza ubzp.

ADDRESS_____ **CITY**_____ **STATE** _____ **ZIP CODE**_____

RELATIONSHIP_____ **GENDER** Female Male

Pokrewienstwo

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Peter Huskowski M.D. to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, progress and treatment plan. I understand that I have the right to inspect any material released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Peter Huskowski, M.D. I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

I hereby authorize payment of Medical Benefits to Peter Huskowski, M.D. for services rendered. I give Peter Huskowski, M.D. consent to treat myself or my minor child.

I understand that if I fail to pay, Peter Huskowski, M.D. reserves the right to take legal action (i.e. collection services, small claims court), and that I will be responsible for all costs involved. (collection fees, court fees)

Acknowledgement and Agreement of above

X_____ _____

Patient Signature (Parent or Legal Guardian) Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare Benefits be made on my behalf to Peter Huskowski, M.D. for any services furnished to me by Peter Huskowski, M.D. I understand my signature authorizes the release of any information needed to process my claims.

X_____ _____

Patient Signature (Parent or Legal Guardian) Date

Dr. Piotr Huskowski
1005 Clifton Avenue
Clifton, NJ 07013

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:

_____

Relationship to Patient:

_____

Signature:

_____

Date:

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

MEDICATION LIST

PATIENT NAME_____DOB_____

PHARMACY NAME_____

PHARMACY ADDRESS_____CITY_____ZIP CODE_____

ALLERGIES-DRUG REACTIONS_____

MEDICATION LIST LISTA LEKOW	DOSE Dawka	