St. Luke's Roosevelt
A Member of the Mount Sinai Health System

SLR Psychiatric Associates
Patient Registration Form

Patient Name: _____

Address: _____

_____

Telephone: _____ E-Mail: _____

Date of Birth: _____ Social Security #: _____

Gender: Male Female

Marital Status: Single Married Committed Relationship Divorced Separated Widow

Emergency Contact Information

Name: _____

Relationship: _____

Emergency Contact Number(s): _____

Insurance Information

Primary Insurance Company: _____

Insurance Telephone: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____

Relationship to Patient: Self Parent/Guardian Spouse Other: _____

Secondary Insurance Company: _____

Insurance Telephone: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____

Relationship to Patient: Self Parent/Guardian Spouse Other

OFFICE USE ONLY

Co-Payment:	_____	Precertification Required?	Yes No
Deductible:	_____	Deductible Met?	Yes No
# Visits Allowed:	_____	Out of Pocket Maximum:	_____

Rev. 1/2014

St. Luke's
Roosevelt

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Mount Sinai Health System

SLR Psychiatric Associates
St. Luke's – Roosevelt Hospital Center

Release of Information

I, _____, hereby authorize and direct SLR Psychiatric Associates, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date _____ _____
Signature of Patient or Authorized Representative

Assignment of Benefits

I, _____, hereby assign, transfer, and set over to SLR Psychiatric Associates and its representatives treating me sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

Date _____ _____
Signature of Patient or Authorized Representative

Medicare Benefits

I, _____, certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to SLR Psychiatric Associates and authorize SLR Psychiatric Associates to submit a claim to Medicare for me.

Date _____ _____
Signature of Patient or Authorized Representative

St. Luke's Hospital

A Member of the Mount Sinai Health System

Department of Psychiatry, Faculty Physician Practice

PATIENT NOTIFICATION RECORD

I acknowledge that I have been given the following Notices as required by State and Federal Regulations:

1. **New York State Patients' Bill of Rights**

2. **St. Luke's – Roosevelt Notice of Privacy Practices**

and consent to share my health information for payment, treatment and hospital operation purposes.

_____

Patient Name (Print)

_____ _____

Patient/Personal Representative Signature **Date**

_____ _____

Representative Relationship to Patient **Date**

St. Luke's Roosevelt

A Member of the Mount Sinai Health System

SLR Psychiatric Associates
1090 Amsterdam Avenue
New York, NY 10025-1737

Credit Card Authorization Letter

I, _____ authorize the use of my credit card described below for charges related to professional services provided by SLR Psychiatric Associates

Credit Card Type ☐ **Debit** ☐**Credit**

☐**Visa** ☐**MasterCard** ** **American Express** ☐ **Discover**

Credit Card Number _____

Expiration Date _____

Name of Card Holder ___ _____

Your address as it appears on your billing statement:

_____
Street Address Apt

_____
City State Zip Code

NOTE: MUST INCLUDE A COPY OF FRONT AND BACK OF THE CREDIT CARD, THE BACK OF CARD MUST BE SIGNED.

I understand that the amount charged to my credit card will be reflected on my credit card statement within seven (7) days of authorization.

_____ _____
Signature **Date**

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CANCELLATION/NO SHOW POLICY

After your initial consultation with Dr. Merling, please be advised that you will be charged for any cancellations made less than 24 hours before your scheduled appointment or for any no-shows.

The cancellation/no show fee will be $_____ (to be discussed at first appointment).

_____ _____

Signature Date