WESTERN NEW YORK BloodCare
SPECIALISTS • LAB • PHARMACY

PATIENT REGISTRATION

Name: _____ **DOB:**_____

Address: _____

_____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email: _____ **Parent/ Guardian:** _____

Please Select Race | Please Choose Ethnic Group | Preferred Language | Gender

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
NAME		
ID #		
GROUP #		
SUBSCRIBER'S NAME		
SUBSCRIBER'S DOB		
EMPLOYER		

Western New York BloodCare will submit a bill to the insurance provider(s) that you have indicated.

I authorize the release of any pertinent medical information necessary to determine liability for payment and to obtain reimbursement of any claim to insurance carriers.

I understand that I am financially responsible to Western New York BloodCare for all charges. I am responsible for all deductibles, co-payments, and must remit to Western New York BloodCare all payments made to me by my insurance company/companies.

Signature _____ **Date** _____

TURN OVER

1010 Main Street Suite 300 Buffalo, NY 14202 TEL: 716.896.2470 FAX: 716.218.4000 www.wnybloodcare.org

Diagnostic and Treatment Center

WESTERN NEW YORK BloodCare
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PRIMARY MEDICAL PHYSICIAN:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

OBGYN (if applicable):

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PHARMACY:

Name: _____

Address: _____

_____

Phone: _____

Fax:

DENTIST:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Patient Name:

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I have received the Notice of Privacy Practices from WNY Bloodcare, which sets forth the ways in which my protected health information (PHI) may be used or disclosed by WNY Bloodcare, and outlines my rights with respect to such information.

WNY Bloodcare realizes that you may have family members or significant people in your life who you may wish to have access to certain information contained in your medical record. Without your written consent, we are not able to release any information to anyone other than for the purposes outlined in the Notice of Privacy Practices.

I authorize that the following specific person(s) be allowed access to my protected health information:

(example: spouse/parents/ family/ friends **)**

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1. *name*_____ *relationship*_____ *phone number*_____

2. *name*_____ *relationship*_____ *phone number*_____

3. *name*_____ *relationship*_____ *phone number*_____

I give my permission to: (initial all that apply)

_____ ☐ Leave a message on my answering machine/ voicemail regarding appointments and/or follow up care

_____ ☐ Send me an email at : _____ regarding appointments and/or follow up care

_____ ☐ I prefer appoinment reminders by: (check all that apply) ☐ phone call ☐ text message ☐ email

Patient Name (printed): _____ DOB: _____

Patient Signature: _____ Date: _____