ROCKLAND ENDOCRINE & DIABETES SERVICES, P.C.

Michael Aronwald, M.D.
Endocrinology

Valeria Silberman, M.D.
Internal Medicine

Yuriy Gurevich, D.O.
Endocrinology

Julia Kaplun, M.D.
Endocrinology

Jonathan Schlosser, D.O.
Endocrinology

Janna Cohen-Lehman, D.O.
Endocrinology

PLEASE PRINT

DATE _____

PATIENT'S NAME _____

DATE OF BIRTH _____ SEX ❑ M ❑ F AGE _____

PARENT'S NAME _____ PATIENT'S SOCIAL SECURITY NO. _____
(IF PATIENT IS A MINOR)

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)* _____

CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____ CELL PHONE ( ) _____ E-MAIL _____

BY YOUR SIGNATURE BELOW YOU ARE ACKNOWLEDGING THAT IF YOUR INSURANCE DOES NOT COVER YOUR OFFICE VISIT, OR IF YOUR REFERRAL IS NOT UP TO DATE FOR THIS VISIT OR ANY VISIT IN THE FUTURE, YOU ARE RESPONSIBLE FOR FULL PAYMENT.

PATIENT SIGNATURE _____

HIPAA

I hereby give my consent for Rockland Endocrine and Diabetes Services, P.C. (the "Practice") to communicate with me by the communication methods listed below.

❑ Text ❑ E-Mail ❑ Cell ❑ Home

HIPAA – Health Insurance Portability and Accountability Act prompted new federal regulations, which require physicians to ensure they are protecting the privacy and security of patients' medical information.

Your signature will allow us to transmit your information to your insurance companies as well as share your medical records with other physicians, medical groups including radiologists on a need to know basis.

In addition you have the right to request disclosure of your information to family members, other relatives, or any other person identified by you. Please list below.

NAME _____ RELATIONSHIP _____
(Please Print)

NAME _____ RELATIONSHIP _____
(Please Print)

NAME _____ RELATIONSHIP _____
(Please Print)