

UBMD Primary Care

Jennifer S. Abeles, DO
Michael Aronica, MD
Andrew Baumgartner, MD
Roseanne Berger, MD
Scott Darling, MD
Frederick Michael Elliott, MD
Steven Foulis, MD
Deepa Gosine, MD
Kevin Hughes, MD
Marlon Koenigsberg, PhD
Peter Kowalski, MD
Michelle Lombardo, MD
Robert Macek, MD
Andrea Manyon, MD
Ashley McCorkle, MD
Daniel Morelli, MD
David Newberger, MD
Sangrok Oh, DO
Christina L. Padgett, DO
Gregory Schenk, MD
Andrew Symons, MD, MS
David Thomas, MD
Diana Wilkins, MD
Kimberly Wilkins, MD
Sarah Adams, PA
Ashley Coe, PA
Katherine Duman, PA
Lauren Merkle, PA
Julie Schmidt, PA

For more:

ubmd.com
ubmdprimarycare.com

Welcome to UBMD Primary Care!

Thank you for selecting your Primary Care Physician with UBMD Primary Care. An appointment has been reserved for you on:

_____ with Dr. _____.

Before your first visit:

- Call your health insurance company and list Dr. _____ as your new Primary Care Physician (PCP). Some insurance companies require this.
- A medical record release has been enclosed for your convenience, or, if you prefer, you may contact your current primary care physician's office directly to request that your records be transferred to our office.
- Please complete the enclosed New Patient Health History and sign the enclosed Financial Policy. Please return the enclosed forms to us no later than _____ (by mail, fax or drop off).

Please Note: Failure to return the completed patient information forms by the above date will result in the automatic cancellation of your new patient appointment. We thank you in advance for your cooperation regarding this policy.

On your first visit, please bring:

1. Your current insurance card
2. Your co-pay/co-insurance or deposit (if applicable). We accept cash, check, Visa, MasterCard, Discover, and American Express.
3. Government-issued photo ID
4. All medication bottles

Please arrive 20 minutes prior to your scheduled appointment time. If you need to cancel your appointment for any reason, please allow a minimum of 24 hours' notice.

WELCOME!

A MEMBER OF



UBMD Primary Care

Jennifer S. Abeles, DO
Michael Aronica, MD
Andrew Baumgartner, MD
Roseanne Berger, MD
Scott Darling, MD
Frederick Michael Elliott, MD
Steven Foulis, MD
Deepa Gosine, MD
Kevin Hughes, MD
Marlon Koenigsberg, PhD
Peter Kowalski, MD
Michelle Lombardo, MD
Robert Macek, MD
Andrea Manyon, MD
Ashley McCorkle, MD
Daniel Morelli, MD
David Newberger, MD
Sangrok Oh, DO
Christina L. Padgett, DO
Gregory Schenk, MD
Andrew Symons, MD, MS
David Thomas, MD
Diana Wilkins, MD
Kimberly Wilkins, MD
Sarah Adams, PA
Ashley Coe, PA
Katherine Duman, PA
Lauren Merkle, PA
Julie Schmidt, PA

For more:

ubmd.com
ubmdprimarycare.com

A MEMBER OF



Our Policy

Follow-Up Appointments:

- If you are more than 15 minutes late for your scheduled appointment, we reserve the right to reschedule your appointment to another day. If you are excessively late for 3 scheduled appointments, or NO SHOW for 2 appointments, we reserve the right to discharge you from our practice.
- All co-payments and co-insurances are due in full at the time of your visit.
- Same day appointments are available for urgent issues.
- We provide equal appointment availability for all of our established patients regardless of insurance status or type of insurance.

Prescriptions:

- NO prescriptions (new or refills) can be written for new patients until you have been in our office to establish care.
- Future refill requests for routine/maintenance medication should be requested through your pharmacy. Your pharmacy will contact us electronically if a prescription is needed.
- Refills are authorized by your provider (or covering provider) within 1-2 business days.
- Prescriptions for controlled substances may not be filled at your first new patient appointment. This will be done at the discretion of the Provider.

If you have any questions, please feel free to contact the office.

Amherst Office
850 Hopkins Road
Williamsville, NY 14221
Phone: 716.688.9641
Fax: 716.932.7465

Conventus Office
1001 Main Street, 4th Floor
Buffalo, New York 14203
Phone: 716.550.8361
Fax: 716.323.0585

Sheridan Office
2465 Sheridan Drive
Tonawanda, NY 14150
Phone: 716.835.9800
Fax: 716.835.9876

Pediatric New Patient Form

Patient Name: _____ **Date of Birth:** ____/____/____

Parent Information:

Parent 1 Name: _____ Date of Birth: ____/____/____
 Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____
 Address: _____

Is this the same address as your child? Y / N Are you a patient of UBMD Primary Care? Y / N

Parent 2 Name: _____ Date of Birth: ____/____/____
 Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____
 Address: _____

Is this the same address as your child? Y / N Are you a patient of UBMD Primary Care? Y / N

Other members of the household:

1. _____ Patient of our office: Y / N
 Last Name First Middle Date of Birth
2. _____ Patient of our office: Y / N
 Last Name First Middle Date of Birth
3. _____ Patient of our office: Y / N
 Last Name First Middle Date of Birth

Emergency Contact: _____ Phone #: (____) _____
 Relationship to the Patient: _____ Is this person on HIPAA? Y / N

Previous Physician's Name: _____
 Practice Name: _____
 Office #: (____) _____ Fax #: (____) _____

Preferred Pharmacy: _____ Phone #: (____) _____
 Address: _____

Insurance:

Primary Insurance Name: _____
 Policy Holder: _____ Relationship to Patient: _____
 Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____
 Member ID: _____ Group #: _____

- Race:** African American
 American Indian/Alaskan Native
 Asian/Pacific Islander
 Caucasian
 Multi-Racial
 Other
 Prefer not to answer

- Ethnicity:** Hispanic or Latino
 Not Hispanic or Latino

Patient Name: _____ **Date of Birth:** ____/____/____

Medical: Please check if your child has had any of the following.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Exposed to Tuberculosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hives | <input type="checkbox"/> Bladder/Kidney infections | <input type="checkbox"/> Severe burns |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vision/Hearing problems | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Elevated Lead | <input type="checkbox"/> Anemia/Blood problems | <input type="checkbox"/> Eczema/Skin rashes | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Heart disease |

Medications: Please list the name of any medications your child takes, the dose, and the frequency.

1.	_____	_____	_____
	Medication	Dose	Frequency
2.	_____	_____	_____
	Medication	Dose	Frequency
3.	_____	_____	_____
	Medication	Dose	Frequency
4.	_____	_____	_____
	Medication	Dose	Frequency

Hospitalizations/Surgeries: Please include type of surgery/illness, date and hospital.

1. _____
2. _____
3. _____

Allergies: Please list any allergies to medication or food.

Have any family members had the following? Please list family member.

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia: _____ | <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Epilepsy: _____ |
| <input type="checkbox"/> Heart disease: _____ | <input type="checkbox"/> Depression: _____ | <input type="checkbox"/> Arthritis: _____ |
| <input type="checkbox"/> GI issues: _____ | <input type="checkbox"/> Stroke: _____ | <input type="checkbox"/> High Cholesterol: _____ |
| <input type="checkbox"/> Liver disease: _____ | <input type="checkbox"/> Kidney disease: _____ | <input type="checkbox"/> Developmental disability: _____ |
| <input type="checkbox"/> Crohn's/Colitis: _____ | <input type="checkbox"/> Drug/Alcohol abuse: _____ | <input type="checkbox"/> Dementia: _____ |

Additional Family History:

Patient Name: _____ Date of Birth: ____/____/____

Safety Issues:

Does your child use car safety restraints? Y / N

Are there any unsecured guns in the home? Y / N

Are there smoke detectors in the home? Y / N

Are there carbon monoxide detectors in the home? Y / N

Does your child eat 5 or more servings of fruits/vegetables daily? Y / N

How many hours does your child sleep at night? _____

Please provide an immunization record for your child. This can be faxed to us by their previous doctor.

(See fax numbers below.)

Amherst Office
850 Hopkins Road
Williamsville, NY 14221
Phone: 716.688.9641
Fax: 716.932.7465

Conventus Office
1001 Main Street, 4th Floor
Buffalo, NY 14203
Phone: 716.550.8361
Fax: 716.323.0585

Sheridan Office
2465 Sheridan Drive
Tonawanda, NY 14150
Phone: 716.835.9800
Fax: 716.835.9876



Dear Patient,

We ask all new patients at UBMD Primary Care to completely fill out the records release form on the following page. Please have your records sent to us via fax or mail (paper copies). We are not able to accept CDs, USB drives or password-protected electronic files.

Incomplete forms may be returned and will cause delays in receiving your records.

Welcome to UBMD Primary Care!

**UBMD PRIMARY CARE
OF AMHERST**
850 Hopkins Road
Williamsville, NY 14221

**UBMD PRIMARY CARE
AT CONVENTUS**
1001 Main Street, 4th Floor
Buffalo, NY 14203

**UBMD PRIMARY CARE
AT SHERIDAN**
2465 Sheridan Drive
Tonawanda, NY 14150

**UBMD PRIMARY CARE -
ADDICTION MEDICINE**
850 Hopkins Road
Williamsville, NY 14221

Patient Name:	Date of Birth: / /	Email Address:
----------------------	------------------------------	-----------------------

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the UBMD Primary Care Notice of Privacy Practice (also available at UBMDPRIMARYCARE.COM).

Signature:	Date: / /
------------	--------------

Patient refused and/or unable to sign.
Staff member signature:

**AUTHORIZATION TO RELEASE INFORMATION TO FAMILY AND/OR FRIENDS
(BE SURE TO INCLUDE YOURSELF)**

Name	Relationship	Primary Phone	Secondary Phone

AUTHORIZATION TO LEAVE MESSAGES

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you.

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Voice Mail on Alternate Phone Number	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		May we send a message?	
Send through US Mail		<input type="checkbox"/> Yes <input type="checkbox"/> No	

RESTRICTIONS TO RELEASE OF INFORMATION

Please list any restrictions regarding information to be released:

SIGNATURE

Signature:	Date: / /
------------	--------------

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.



Patient Financial Policy

Thank you for choosing UBMD Primary Care for your medical care. We are dedicated to providing the best possible care for you. We offer the following information to help you understand our financial policy and to aid you in planning for payment.

UBMD Primary Care believes that financial difficulties should not prevent you from receiving the medical care that you need, when you need it. Please contact our Billing Department to discuss any concerns. Payment plans are available if needed. Our Billing Department may be reached at: 1.866.853.9551 Option 4.

Insurance Verification and Co-payments

You are expected to present an insurance card at each visit. We will bill your primary insurance company as a courtesy. Failure to provide complete insurance information to us may result in your responsibility to pay the entire bill. All co-payments, deductibles and past due balances are due at the time of service. Failure to pay your co-pay at time of service will result in an additional \$10.00 fee. All payments are expected to be made in U.S. dollars. UBMD Primary Care accepts cash, personal check, and credit card (Visa, MasterCard, American Express, Discover). There is a \$35.00 fee for returned checks.

It is your responsibility to be aware of the details of your insurance coverage, including any requirements for referrals or pre-authorization. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage when scheduling an appointment. In addition, please ensure that you have designated a UBMD Primary Care physician as your Primary Care Physician (PCP) if your insurance company requires you to designate a PCP (not applicable to Addiction Medicine).

Self-Pay Accounts

Patients without insurance coverage, patients without an insurance card on file with the practice, or whose insurance is not accepted by the practice have “self-pay” accounts. This includes patients who have applied for Medicaid who do not yet have a valid Medicaid number. Liability cases are considered self-pay accounts unless a case number is provided. UBMD Primary Care does not accept attorney letters or contingency payments. If there is a discrepancy with the insurance information you provided to UBMD Primary Care, you will be considered self-pay until otherwise proven. If you are a self-pay patient, you will be expected to make a down payment of at least \$150.00 at the time of service. If this down payment does not cover all treatment charges, you will be billed for the remaining balance (or issued a refund within 60 days if your overall patient account has a credit balance).

Failure to make your deposit at time of service will result in an additional \$10.00 fee.



High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)

If your insurance is a High Deductible Plan you will be required to make a down payment of at least \$75.00 at the time of service. If the total cost of services rendered is more than down payment you will be billed for the remaining amount. If the cost of your visit is less than the down payment we will send you a refund of the difference within 60 days if the deposit causes your overall patient account to have a credit balance.

No-Fault/Workers Compensation

You are responsible for providing our office with all information required to properly submit charges on your behalf (name of insurer, address, claim number, date of injury, etc.). Without this information you will be responsible for payment for the full cost of your visit(s). If you have private insurance with which we participate and you obtain any necessary referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

Medicare

We are “participating physicians” with Medicare. This means that we must accept Medicare’s allowed charge for services rendered. Traditional Medicare will pay 80% of the approved amount. You are responsible for the remaining 20% plus any deductible that your plan may require. This payment is due at the time of service. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance to your secondary insurance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

Responsibility for Minors

The parent/guardian who holds the insurance policy for the child is considered the guarantor for the child and is responsible for payment regardless of personal circumstances.

No-Show/Cancellation Fee

A fee of \$35.00 may be charged for any appointments missed or not canceled at least 24 hours before the scheduled visit. It is your responsibility to notify the office when an appointment needs to be canceled or rescheduled.

Form Completion Fee

There will be a \$10.00 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of the request. Please allow at least one week for forms to be completed.

**Late Fees**

Payment is due within 30 days from the date of the initial billing statement. A \$10.00 late fee will be assessed on each statement generated after the first statement until the outstanding balance is paid. Please contact the billing department if you are unable to pay your balance so a payment plan can be set up, and late fees may be avoided.

Referrals and Authorizations

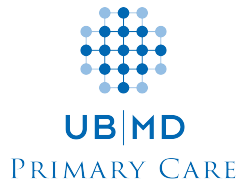
Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Past Due Accounts and Failure to Follow Payment Arrangements

Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made within 120 days, your account will be turned over to a collection agency.

Financial Difficulties

We encourage our patients to discuss any unexpected financial circumstances with our Billing Department. We realize that financial difficulties may sometimes arise and the Billing Department will work with you to make a payment plan under these circumstances.



Release of Information

By signing below, you authorize the release of necessary medical information to UBMD Primary Care for the purpose of processing any claims. You also authorize UBMD Primary Care to release and obtain any information pertinent to your case for purposes of payment.

Assignment of Payment

By signing below, you authorize payment directly to UBMD Primary Care for the surgical and/or medical benefits, if any, otherwise payable to you under the terms of your insurance.

By signing below, you acknowledge that you have read, understand, and will cooperate with the financial policy of UBMD Primary Care.

Patient Name (Printed)

Patient Date of Birth

Patient Signature or Responsible Party if Minor

Date

Policy effective date: 03.24.2014
Last reviewed/revised: 11.29.2017, 02.05.2018, 02.01.2024, 03.28.2024