Patient Concierge Services

HELPING YOU RECEIVE THE BEST HEALTH CARE

Fax: (888) 248-8572
Tel: (888) 248-9002

Referring Doctor _____

PATIENT INFORMATION

Last Name: _____

First Name: _____

Date of birth *(MM/DD/YYYY)*: _____ / _____ / _____

Contact Phone (cell /home): _____

e-Mail address: _____

Insurance Carrier: _____

☐ I would like to be notified of my appointment via text message

APPOINTMENT

PREFERRED DATE & TIME

☐ Mon ☐ Tues ☐ Wed
☐ Thues ☐ Fri ☐ Sat

☐ Morning ☐ Afternoon ☐ Evening

Location (City or Zip Code) _____

SERVICE REQUESTED

☐ Cardiology	☐ Radiology: MRI / CT Scan / X-Ray	☐ Pain Management
☐ Gastroenterology		☐ Physical Therapy
☐ Ophthalmology	☐ Podiatry	☐ Psychiatry
☐ Urology	☐ GYN/OB	☐ Endocrinology
☐ Neurology	☐ Rheumatology	☐ Dentistry
☐ ENT (Ear, Nose and Throat)	☐ Plastic Surgery	☐ Aesthetics
	☐ Orthopedic Care	☐ Pulmonology
☐ Dermatology	☐ Pediatric Care	☐ General/Vascular Surgery

Other: _____

I would like to be seen by *(Physicians Name)* _____

SPECIAL REQUEST

_____

_____

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Patient Concierge Services Inc. (PCS) *is an independent medical management and scheduling company operating independently of a Patients primary care provider. PCS by and through agreements with many of New York's Specialty Providers provides its services free of charge to Patients and their Primary Care Provider. PCS provides You, the Patient, the ability to find a nearby doctor, dentist, lab and/or imaging center that accepts your insurance, conducts required pre-authorizations and then books and confirms your appointment with the needed health care provider; with PCS the patient often sees the referred to health care provider within 24 hours. The above information is correct to the best of my knowledge and I agree not to hold PCS responsible for any errors and/or omissions that I, or my Primary Care Provider, may have made in completing this form. My signature on this Form below represents my approval and use of my protected health information for the limited use indicated set forth in this Form. I authorize PCS to contact me via phone, e-mail or text messaging if necessary.*

Patient Signature: _____ Date: _____