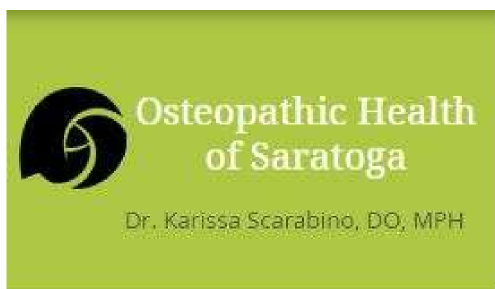


28 Clinton Street, Suite 3
Saratoga Springs, NY 12866
(t) 518.250.3221

Dear New Patient,

Thank you for choosing to make your first visit with me at Osteopathic Health of Saratoga! Welcome to my practice.

Please print and complete these forms to bring with you to your first appointment. On the day of your scheduled appointment please do the following:

• Arrive 20 minutes prior to your appointment to allow time to process your paperwork and complete the registration process.

• Bring your insurance ID and driver license (photo I.D.).

• Bring the your most recent medical records; including: most recent radiology reports that pertain to the reason for your visit (x-rays, MRI'S, CAT scans, etc.), along with any related studies such as NCS/EMG's and bloodwork.

Please bring a copy of your immunization records.

• Wear comfortable, loose fitting clothing. No skirts or dresses please.

• WE ARE A FRAGRANCE-FREE OFFICE. Please do not wear perfume or colognes on the day of your appointment.

• Allow at least 90 minutes for your first visit.

PLEASE NOTE: Please call twenty-four hours ahead if you will need to cancel or reschedule an appointment. A missed appointment fee of $75.00 will be charged to your account if I do not receive notification in advance. If you have any questions, please feel free to contact us.

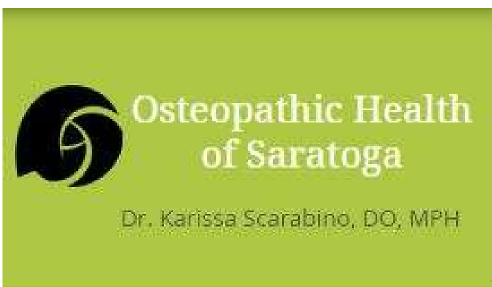
Please feel free to contact the office with any questions or concerns about your upcoming visit. I am honored to be a new part of your healthcare. I very much look forward to meeting you!

(Enclosed find your new patient packet, which contains directions to our office, patient registration information, information disclosure consent, insurance information, and your initial office visit form. Please complete the relevant portions as accurately as possible and bring them along for your appointment.

Warmest Regards,

Dr. Karissa Scarabino, DO, MPH

Osteopathic Health of Saratoga



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HIPPA

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS.

PLEASE COMPLETE THE ENTIRE FORM.

**This notice informs us on how you would like your medical information disclosed.

PLEASE READ CAREFULLY.

Patient Name: _________________________ Date of Birth: __________________

Do we have your permission to send appointment reminders to your home? Y or N

Email you with appointment updates/changes? Y or N

Please give us your email address: _______________________________

Do we have permission to leave the following on your home answering/voice mail:

Appointment information? Y or N Billing information? Y or N Medical information? Y or N

I give permission to share billing, appointment and medical information with the person(s) listed below:

Name ________________________________ Relationship ___________________

Name ________________________________ Relationship ___________________

I authorize the office of Dr. Karissa Scarabino to send or obtain my medical records to/from the following physicians:

1. _________________________________ 2. _________________________________

3. _________________________________ 4. _________________________________

5. _________________________________ 6. _________________________________

I understand that my medical records may contain information about but not limited to alcohol and/or drug treatment, mental health or psychiatric, and/or HIV/AIDS information. I do expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need indicated above. • I understand that certain records may be sent via fax and I relieve Sarasota Osteopathic Medicine employees, and/or agents any liability from mistransmission by fax. • A photocopy of this authorization shall have the same effects as the original.

Patient Signature _____________________________________ Date ____________________