

Patient Information Sheet

Welcome to our Office...

Attention: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security#		
First Name:	Last Name:	Middle Initial:
Date of Birth: (MM/DD/YYYY) ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Address:	City:	State: Zip:
Home Phone: (____) _____	Work Phone: (____) _____	Cell Phone: (____) _____
Emergency Contact:	Emergency Telephone#: (____) _____	
Employer Name:	Employer's Address / City / State / Zip	

Referring Doctor:	Referring Dr.'s Address / City / State / Zip	Ref. Dr. NPI #
Primary Care Physician:	Primary Care Physician's Address / City / State / Zip	P.C.P. NPI #

Patient's Insurance Information

<u>Primary</u> Insurance Company Information:	<u>Secondary</u> Insurance Company Information:
Policy Holder Information	Policy Holder Information
First Name:	First Name:
Last Name:	Last Name:
Policy Holders SS#	Policy Holders SS#
Policy Holders Date of Birth:	Policy Holders Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Policy Holder's Address: <input type="checkbox"/> Same as patient	Policy Holder's Address: <input type="checkbox"/> Same as patient
City: State: Zip:	City: State: Zip:
Insurance's Name:	Insurance's Name:
Policy ID: Group #:	Policy ID: Group #:
Claim Submission Address:	Claim Submission Address:
Effective Date: ____/____/____	Effective Date: ____/____/____
Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____	Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____
Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No

Responsible Party Information – Please complete if the responsible for payment is not the <u>Patient</u> or the <u>Policy Holder</u> .		
Responsible Party's Name (Last / First):	Responsible Party's SSN:	Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Responsible Party's Address / City / State / Zip:		

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.

Today's Date: _____ Patient's Signature (or parents if under 18 years of age): _____

FINANCIAL AGREEMENT

1. Individual's Responsibility for Non-Covered Services:

In consideration of services rendered by Dr. Levine/Feingold to the undersigned patient, undesired promise(s) to pay to Dr. Levine/Feingold any co-payment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of some prior to the rendering of said services.

2. Assignment of Benefit Proceeds:

I hereby assign to Dr. Levine/Feingold all monies and/or benefits to which I am entitled from my insurer/HOM/third-party payor, government agencies, or those who are financially liable for my medical care.

3. Authorization to Release Records:

I hereby authorize Dr. Levine/Feingold to release to my insurance/HMO/third-party, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

It is, however expressly understood that there will be no obligation of the undersigned to pay for any services which are not Medically necessary or improperly billed.

ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

This is to acknowledge notification of Privacy Practices by Offices of Dr. Levine/Feingold.

I request a copy of the Notice of Privacy Practices: _____

I do not request a copy of the Notice of Privacy Practices: _____

Disclosure of Person involved in my care are listed below, I authorize my doctor and their representative to release my protected health information to those listed as it relates to my care.

Name

Relationship

Name

Relationship

Patient/ Responsible Party Signature