Patient Registration Form

Patient's Name: _____

Street Address: _____

City, State and Zip: _____

Phone Number: _____ Alternate Number: _____

Date of Birth: _____ Sex (M or F): _____

Marital Status : _____ Social Security Number: _____

Responsible Party (for a minor): _____

Employer: _____

Work Phone: _____

Insured's Name: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Is Medicare your primary insurance? YES or NO

Medicare Number and suffix: _____ Effective Date: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Place of Service: Bronxville or White Plains

Were you referred by another doctor? ..... YES or NO

If yes, name? _____

Were you referred by a friend? ..... YES or NO

If yes, name (optional): _____

Did you use the Yellow Pages? ..... YES or NO

Did you use the Internet? ..... YES or NO

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PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

In an effort to provide you with quality health care and flexible payment arrangements, we have expanded our payment policy.

I will be paying by the following method, (<u>please check one</u>):

- ❑ **MEDICARE** – 20% of the approved amount **ONLY,** after deductible
- ❑ **CASH**
- ❑ **CHECK**
- ❑ **CREDIT CARD**
- ❑ **CO-PAYMENT**
- ❑ **DEDUCTIBLE***

*If you have not met your deductible you are responsible for the entire bill.

Please see the accompanying list of insurance plans in which we participate.
If you have another type of insurance plan you must pay at the time of service. We will give you a receipt with all of the information that your insurance company requires so that you can immediately submit this to your insurance company for reimbursement.

If you need special considerations please speak with the office manager before seeing the doctor.

FOR ALL PATIENTS:

I understand that I am responsible for all charges for services rendered to me, including the balance remaining after payment of possible insurance benefits according to my individual insurance contract.

Payment is due at the time of service unless other arrangements are made with the office manager prior to seeing the doctor. If it is agreed that these charges will be submitted to my insurance company, I agree to pay the balance in full if payment is not received within 45 days from the date of service.

SIGNED _____ Date _____

Patient Registration Form

For ANY Insurance Company:

PLEASE SIGN SO THAT WE MAY HAVE YOUR AUTHORIZATION ON FILE.

I authorize any holder of medical or other information about me to release to my insurance company any information needed for this or a related claim. I permit copy of this authorization to be used in place of the original, and request any payment of medical insurance befits to the party who accepts assignment.

SIGNED _____ Date _____

FOR MANAGED CARE, HMO and POS INSURANCE POLICY HOLDERS:

If my insurance plan requires approval to authorize or pre-certify treatment, a referral form from my primary care physician or any other requirement, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN THESE ITEMS. If I fail to adhere to any of my insurance plans requirements or do not obtain a proper referral, which results in non-payment of fees by my insurance company I understand that I will be personally responsible to pay the full contractual amount.

SIGNED _____ Date _____

For MEDICARE patients:

PLEASE SIGN SO THAT WE MAY HAVE YOUR AUTHORIZATION ON FILE.

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this a related claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

SIGNED _____ Date _____

For SUPPLEMENTAL MEDICARE Insurance:

Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (Medigap Coverage).

PLEASE SIGN SO THAT WE MAY HAVE YOUR AUTHORIZATION ON FILE.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

SIGNED _____ Date _____

Patient Registration Form

Office Policies

Referrals:

- ❑ If your insurance company requires that you obtain a referral in advance of your visit, it is your responsibility to make sure you bring it with you or have it sent to us prior to your visit. We regret that we can not call for you.

- ❑ If your primary care doctor's office issues referrals electronically, it is your responsibility to obtain the confirmation/authorization number, the number of visits allowed and the duration of the referral.

- ❑ If you come without a referral, you have two choices:
  1. Pay the minimal, discounted fee for the office visit on the day of service. We will send you a refund when payment is received from your insurance company.
     OR
  2. Reschedule.

- ❑ **We regret that we can not call your doctor's office for you.**

Co-payments:

- ❑ Co-pays are due at the time of service. There are no exceptions. We can no longer afford to bill patients for these nominal fees. If we are forced to bill you for a co-pay, we will charge an additional "billing" service fee to cover this expense.

Missed Appointments:

- ❑ Please remember to cancel appointments at least 24 hours in advance. If you miss a scheduled appointment, we reserve the right to charge you a penalty fee.

Please sign below to confirm that you have reviewed these practice policies and that you understand them. If you have a question please feel free to discuss it with the office manager.

_____ _____

Patient Name (Please print) Date

_____ _____

Patient Signature Date

_____ _____

Signature of Parent (if patient is a minor) Date