CONFIDENTIAL PATIENT INFORMATION

Name_____ SS#_____
Address_____ City_____ State_____ Zip_____
Home Telephone_____ Age____ Birthdate_____ Marital Status: M S W D
Alt. Telephone_____ Occupation _____
In case of emergency, who may we contact?_____
Whom may we thank for referring you?_____
Primary Care Physician:_____ Email Address:_____
Pharmacy Name/Location/Phone:_____

INSURANCE INFORMATION

Primary Insurance Company:_____
Address:_____ Phone:_____
Contract ID Number:_____ Copayment Amount: $_____
Group Number:_____ Subscriber's SS#_____
Subscriber's Name:_____ Insured's Date of Birth:_____
Patient Relationship To Subscriber: (circle one) Self Spouse Child Other

Secondary Insurance Company:_____
Address:_____ Phone:_____
Contract ID Number_____ Copayment Amount: $_____
Group Number:_____ Subscriber's SS#_____
Subscriber's Name:_____ Insured's Date of Birth:_____
Patient Relationship To Subscriber: (circle one) Self Spouse Child Other

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____ and assign directly to Mid island Orthopedics and or Dr.Sider all medical benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

OFFICE POLICY ON PAYMENT

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including all court & attorneys fee.

Signature of Insured/Guardian_____ Date_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either of me or on my behalf to Dr.Jeffrey S Sider for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature_____ Date_____