Dr Russell M Blatstein

(772) 225 – 3668
1635 NE Jensen Beach Blvd
Jensen Beach, FL 34957

(772) 337 – 2920
1226 SE Port St Lucie Blvd
Port St Lucie, FL 34952

PATIENT PERSONAL INFORMATION

General Information

Name: Last First Middle Suffix ☐Dr ☐Mrs ☐Mr ☐Ms	Social Security # – –	Birth Date / /	Sex M / F

Marital Status:	Preferred Language:	Race:	Ethnicity:
☐ Married ☐ Separated ☐ Divorced ☐ Polygamous ☐ Widowed ☐ Annulled ☐ Single ☐ Domestic ☐ Interlocutory Partner	☐ English ☐ Other _____	☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian	☐ Hispanic / Latino ☐ Not Hispanic /Latino ☐ Patient Declined

Contact Information

Primary Method of Contact: ☐ Call ☐ Mail

Home Address: Apt/Lot #	**Primary Phone** ( ) - Ext
City: State: Zip: Country:	**Type:** ☐Home ☐Cell ☐Work Health Related Messages OK? ☐
Out Of State Address: Apt/Lot #	**Secondary Phone** ( ) - Ext
city: State: Zip: Country:	**Type:** ☐Home ☐Cell ☐Work Health Related Messages OK? ☐

Email Address @

Referral Source: ☐Insurance Provider Search ☐Location ☐YellowPages ☐Advertisement ☐Current/Past Patient ☐Dr Referral ☐Friends/Family ☐Other_____

Spouse/Parent Information Last First Middle
Home Address Apt/Lot #
City: State: Zip: Country:
Primary Phone ( ) - Relationship to Patient ☐Parent ☐Guardian ☐Spouse ☐Other

Employment Information

Employer:	Employment Status:
Occupation:	☐FullTime ☐F/T Student ☐Selfemployed ☐PartTime ☐P/T Student ☐Unemployed ☐Retired ☐Active Duty Military

Employer Address:
City: State: Zip: Country:
Employer Phone ( ) - Employed for how long weeks months years

*I/we authorize the Doctor(s), Associate Doctor(s), and staff of the practice named in the heading of this form, to treat patient named on this form and agree to pay all charges and fees for such treatment.
*I/we agree to pay all charges for myself and members of my family per the terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date.
*I/we acknowledge that if any account balance is not paid in full within 60 days, the entire account balance will be subject to a MONTHLY FINANCE CHARGE and a MONTHLY COST OF REBILLING/ACCOUNT MAINTENANCE CHARGE at the rates listed on the reverse side of this form.
*In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree that the prevailing party will be entitled to reasonable attorney's fees and costs as the Court determines proper.
* It is agreed that payments will not be delayed or withheld because of any lawsuits, liens, or insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable. I/we understand that I/we are responsible for paying all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by my/our insurance. Such payments are due at the time of service or immediately upon presentation of the bill.
*I/we agree that we shall remain financially responsible for the above named patient until I/we notify you in writing to the contrary. This guarantee is continuing even if the Actual patient, if a minor, reached the age of maturity.
*I/we authorize you or your agent to make credit investigation, including employment verification. I/we certify this information is true and correct to the best of my/our knowledge. I/we will notify you of any changes in my (the patient's) health or the above information.
This instrument contains the entire and only agreement between the parties and there are no other promises, representations, or warranties, either expressed or implied. The provisions of this agreement shall not be changed or modified except for an instrument, in writing, signed by the parties hereto:
You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.
NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ AND AGREED TO THE CONDITIONS SET FORTH ON THIS FORM.
I/we hereby acknowledge the receipt of a copy of these terms and charges and agree to them as stated and referred to herein.

X_____**Date**_____/_____/_____
Signed by Patient (Parent must also sign if patient is under 18 years of age)

X_____**Date**_____/_____/_____
Signed by Parent or other legally responsible person

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Fax (772) 334 – 4115

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Port St Lucie, FL 34952
Tax ID 59 – 2591195

DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

*I/we hereby name as assignee and also instruct and direct my/our Insurance Company to pay by check made out and mailed to the assignee:

DR RUSSELL BLATSTEIN
1635 NE JENSEN BEACH BLVD
JENSEN BEACH, FL 34957

*or if my current policy prohibits direct payment to doctors, the I/we hereby instruct and direct my/our Insurance Company to make out the check to me and mail as follows:

DR RUSSELL BLATSTEIN
1635 NE JENSEN BEACH BLVD
JENSEN BEACH, FL 34957

for the professional or medical expense benefits allowable, and otherwise payable to me/us under my/our current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY/OUR RIGHTS AND BENEFITS UNDER THIS POLICY.

*I/we grant the assignee a limited Power of Attorney to sign my/our name, deposit and negotiate any Insurance payment received and apply it to my/our outstanding balance. These payments will not exceed my/our indebtedness to the above mentioned assignee, and I/we have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment. This assignment shall remain in effect until cancelled in writing by the assignee.

*I/we agree that a photocopy of this Agreement shall be considered as effective as the original.

*In order that the assignee may submit a claim for payment for services covered under my/our policy, I/we give the assignee authorization to release medical, billing and collection information to my/our insurance carrier and vice versa.

*FOR MEDICARE: I/we authorize any holder of medical information about me/us to release, to the Health Care Financing Administration and its agent, any information needed to determine these benefits or the benefits payable for related services. I/we hereby authorize Medicare to furbish to you any information regarding my/our Medicare claims under Title XVIII of the Social Security Act.

X_____Date_____/_____/_____
Signature of Policyholder

X_____Date_____/_____/_____
Signature of Patient (if other than Policy holder)

ACCOUNT TERMS AND PAYMENTS FOR NON-INSURANCE COVERED ITEMS AND SERVICES

When you account has balances over 60 days:

Your MONTHLY FINANCE CHARGE IS 1.00% ANNUAL PRECENTAGE RATE 12.00%.

Your MONTHLY COST OF REBILLING / ACCOUNT MAINTENANCE CHARGE IS $8.00

Today I will pay my bill by:

Cash Check #_____ Visa Mastercard Discover

In the future I can pay my bill by:

Cash Check #_____ Visa Mastercard Discover