TODAY'S DATE _____

WHO CAN WE THANK FOR REFERRING YOU?_____

PATIENT INFORMATION

PATIENT'S NAME_____

PATIENT'S SOCIAL SECURITY #_____

MAILING ADDRESS _____

_____

CITY, STATE, ZIP CODE

PATIENT'S TELEPHONE # _____

NAME & PHONE # OF NEAREST RELATIVE _____

NAME & PHONE OF CONTACT PERSON IF OTHER THAN ABOVE

_____

PATIENT'S AGE _____ PATIENT'S DATE OF BIRTH _____

☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

NAME OF SPOUSE _____

(IF CHILD) PARENT'S NAME _____

PARENT'S SSN# _____

PARENT'S ADDRESS IF DIFFERENT THAN CHILD (PATIENT)

_____

EMPLOYER'S NAME_____

" ADDRESS _____

" CITY, ST._____

" PHONE #_____

IF THIS IS AN ON-THE-JOB INJURY:

WHEN DID THE INJURY HAPPEN?_____

HOW DID IT HAPPEN?_____

DID YOU REPORT THE INJURY TO YOUR EMPLOYER?_____

PATIENT'S NAME _____

HOW DO YOU PLAN TO PAY FOR YOUR VISIT?

☐ MEDICARE ☐ MEDICAID ☐ HEALTH INSURANCE ☐ WORKER'S COMP.

☐ SELF PAY ☐ OTHER, please explain _____

In order to file to your insurance, you must provide full information. Be prepared to show your insurance, Medicare, and/or supplement insurance coverage ID cards or Medicaid gold card. We will photocopy them for our use.

Are you personally responsible for the payment of your fee? ☐Yes ☐No If not, who is?
Name _____ Relationship _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and are NOT a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. Some insurance will not pay until your charges go over a certain dollar amount (called a deductible).
   It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. I request that payment of authorized Medicare and/or Insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

AUTHORIZATION FOR MEDICARE OR ANY OTHER INSURANCE:
SIGN HERE _____ **DATE**_____
(Patient-----or parent, if patient is a minor)

(For supplemental insurance)
By signing below, I request payment of my Medicare supplemental benefits to be made on my behalf.
SIGNED _____Name of Supplement_____

ROY Z. BRAUNSTEIN M.D.
749 STATE ROAD 60 EAST
LAKE WALES, FL 33853
863-676-7624

PATIENT ATTESTATION OF INSURANCE INFORMATION

Dr. Braunstein is dedicated to provide the best possible care for you and we want you to completely understand our financial policy. If you have medical insurance, the office will submit the claims on your behalf. We will file your insurance, but if we do not hear from your insurance company after two attempts, we will expect the patient to be responsible for the charges.

It is important that you notify the office of any changes regarding your insurance.

If after filing the insurance per your instructions, we find that you have given us incorrect insurance information, you will be held responsible for the full amount of the charges.

By your signature below, you indicate that you have read the above and understand.

_____ _____

Patient signature **Date**