

Referred By: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Circle: Male or Female

Soc Sec #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Spouse's Information:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact #: \_\_\_\_\_

**Insurance Information:**

Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_

Is the patient covered by additional Insurance:  Y  N

Subscriber's Name \_\_\_\_\_

D.O.B. \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group#: \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Feinerman for any services furnished to me by that doctor. 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 payable for related services. I understand my signature requests that payment be made and authorizes releases 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 the approved claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned case, 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 the non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier

\_\_\_\_\_  
**Signature of Beneficiary**                      **Date**

**Assignment and Release**

I, the undersigned certify that I (or my dependant) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Feinerman all insurance benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all the charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

**Signature** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Date:** \_\_\_\_\_