Gregg Feinerman, M.D., F.A.C.S.

Referred by: ______________________________

Last Name ________________________________ First Name________________________ M.I.____

Address ____

City ______________________________ State _______ Zip Code ____________________

Home Phone (_____)________________________ Work Phone (_____)________________________

E-Mail Address ____

Birthdate ______________ Age_____ Sex □ Male □ Female

Soc Sec # _____-____-_____ Driver's License # _____________ State____

Occupation _______________________ Employer____________________

SPOUSE'S INFORMATION:

Spouse's Name ____

Birthdate ____________________ Soc Sec # ___________________________

Occupation __________________ Employer ________________________

PERSON WE CAN CONTACT IN CASE OF EMERGENCY:

Last Name _______________________ First Name __________________

Relationship ________________ Address ___________________________

City________________________ State______ Zip _____________________

Home Phone (_____)_______________Work Phone (____)____________

PHARMACY INFORMATION:

Please provide your pharmacy information so that we may send your prescriptions directly to the pharmacy.

Name:____

Address: ____

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Phone:____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Feinerman for any services furnished 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 for the benefits payable for 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 releasing 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, coinsurance, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

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Signature of Beneficiary Date

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________________________ and assign directly to Dr. Feinerman all insurance benefits, if any, otherwise payable to me for services 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 insurance submissions.

______________________________ _______________ ________

Responsible Party Signature Relationship Date

PLEASE TURN OVER AND FILL OUT BACK OF FORM