PATIENT REGISTRATION

DANIEL BENDETOWICZ, M.D., P.A.

PLEASE COMPLETE ALL INFORMATION:

Date:

Last Name:

Home Phone #:

First Name: M.I.:

Work Phone #:

If year round resident with only one address, please check here: ❑

Cell Phone #:

LOCAL ADDRESS

Street Address: Apartment #:

Marital Status:

City: State: Zip:

Spouse Name:

Zip Code: Sex: ❑ Male ❑ Female

Spouse DOB:

Social Sec. #: Date of Birth:

Spouse Social Sec. #:

Employer:

Spouse Cell Phone #:

UP NORTH ADDRESS

Address:

Phone #:

City: State:

Zip Code:

INFORMATION RELEASE

LIFETIME MEDICARE B signature authorization for services beginning _____. I authorize any hold of medical or other information about me, including the results of any HIV (human immunodeficiency virus) test, to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carriers, or to my insurance company or any organization or authority, or to the billing agent for Daniel Bendetowicz, M.D., P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment.

PATIENT'S SIGNATURE: MEDICARE #: DATE:

If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:

AUTHORIZED SIGNATURE: RELATIONSHIP TO PATIENT:

AUTHORIZED SIGNATURE'S NAME: DATE:

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I authorize treatment of the patient named herein and agree to pay all fees and charges promptly, unless advance credit arrangements are agreed in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

PATIENT'S SIGNATURE: DATE:

IF PATIENT IS A MINOR

I, _____, the _____, of _____, hereby personally accept financial responsibility for professional services by Daniel Bendetowicz, M.D. P.A., upon the aforementioned child.

SIGNED: DATE:

ASSIGNMENT AND RELEASE

I/We hereby authorize my insurance benefits, including Medicare Gap Fillers, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I/We authorize the physician to release any information required by my insurance, including HIV (AIDS) testing/notes, mental health, alcohol and/or substance abuse. Financial information can be released if the Patient's account number is provided by the person making the request.

PATIENT'S SIGNATURE: DATE:

If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:

AUTHORIZED SIGNATURE: RELATIONSHIP TO PATIENT: DATE:

AUTHORIZED SIGNATURE'S NAME: DATE:

NAME **DATE OF BIRTH**