101-24 Queens Blvd Suite A,
Forest hills, NY 11375
Tel: (718) 261-8881
Fax: (718) 261-8889

(Please print) (Please print)
Last Name___________________________________ First Name _____________________________________

Address___________________________________City___________________State______________________

Zip Code_______Tel#(Home)(____)______________(Cell)(____)____________(Work)(____)____________

Date of Birth ____/____/_______ SS#_____________________________ Male (____) Female (____)

Email Address ____

Marital Status: (_) Single (_) Married (_) Widowed (_) Separated (_) Divorced (_) Other _________________
Referring Physician _______________________________ Tel# _______________________________________
Employer's Name & Address ________________________________ (__) Full Time (__) Part Time
Tel# (____) ________________________

IN CASE OF EMERGENCY:

Contact (Name) _____________________ Relationship ________________ Tel# (____)__________________

****ALLERGIES TO MEDICATIONS:** ____

PRIMARY INSURANCE

Insurance Name________________________ Policy#__________________ Group#______________________
Insurance Address____Tel# (____)__________________________
Insured Name ____________________________D:O:B___/___/___ SS# _______________________________
Address____City________________ Sate____________________
Zip Code_________ Tel# (____) _______________________
Relationship to insured: (___) Self (___) Spouse (___) Child/Dependent (___) Other ____________________

SECONDARY INSURANCE

Insurance Name________________________ Policy#__________________ Group#______________________
Insurance Address____Tel# (____)__________________________
Insured Name ____________________________D:O:B___/___/___ SS# _______________________________
Address____City________________ Sate____________________

Zip Code_________ Tel# (____) _______________________
Relationship to insured: (___) Self (___) Spouse (___) Child/Dependent (___) Other ____________________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts this assignment. I fully understand that I am financially responsible for non-covered services. I authorize payment of medical benefits to the undersigned physical or supplier for services described.

SIGNATURE: ____ Date: __________________________

PHYSICIAN'S SIGNATURE: ____________________________________ Date: __________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

I, ______________________________. (insert patient's name) acknowledge receipt this day from ADVANCED MEDICAL CARE, PLLC of a copy of the NOTICE OF PRIVACY PRATICIES of ADVANCED MEDICAL CARE, PLLC

Date: ______________________ ___________________________

(Patient's Signature)

Received By:

____

(Print Name of staff Member)

____

(Signature of staff Member)

*The completed form is to be placed in the patient's medical record

<u>FINANCIAL POLICY AGREEMENT</u>

I, agree to the following terms and acknowledge the following responsibilities:

I am responsible for the timely payment of my account including co-payments, co-insurance, deductibles and non-covered services. Furthermore, if my insurance company inadvertently pays me directly, I acknowledge that I must send payment to the offices of Advanced Medical Care IMMEDIATELY.

I am aware that it is my responsibility to inform Advanced Medical Care of **any changes** in my insurance coverage. Any charges incurred not covered by the insurance plan(s) that Advanced Medical Care has on record, will be my sole responsibility.

<u>Co-Payments</u>: I am aware that if my insurance plan requires a co-payment, that I and physician are **legally obligated** to abide by this requirement. I will not ask Advanced Medical Care to waive co-pays, unless I can show an extreme financial hardship, as they cannot legally do so.

<u>Medicare Patients:</u> **I am aware that I am fully responsible for my yearly deductible portion not paid by Medicare.** If I have supplemental coverage (Medicaid), Advanced Medical Care will submit the claims for me. Furthermore, if I am enrolled in a Medicare HMO plan, I am aware that it is my responsibility to inform the staff of Advanced Medical Care. If the appropriate referrals are not obtained, I am aware that I am responsible for full payment.

<u>Managed Care Plans</u>: If my plan requires authorization from a primary care physician, **it is my responsibility** to obtain the written referral or authorization number **prior** to my visit with Advanced Medical Care's physicians.

<u>No-Fault/Worker's Compensation</u>: If the reason for my visit is a work related injury or an auto accident, I must inform the front desk so they could discuss my billing situation with the billing staff in advance.

Furthermore, I accept that the Practice will provide treatment to me based upon my agreement to the above terms. I have read, understand and accept the payment policies and my financial responsibilities regarding the services of Advanced Medical Care.

______________________________ ____________

Patient's Signature Date