

The Westchester Medical Practice, P.C.

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN#: _____ Sex: _____ Marital Status: _____

Phones: Home: _____ Cell: _____ Work: _____

Email: _____ Employer: _____ Occupation: _____

Did someone refer you to us? If so, whom may we thank for your referral? _____

Emergency Contact Information:

Name: _____ Phone: _____ Relation: _____

Primary Insurance:

Name of Insurance: _____ ID#: _____ Group #: _____

Name of Policy Holder: _____ Insured SS#: _____ Insured DOB: _____

Address of Policy Holder: _____ (same as patient) _____

If your insurance requires a Primary Care Physician (PCP) who is listed as your PCP with your insurance company:

_____ Effective date of insurance if known: _____

Copayment amount: \$ _____

Secondary Insurance (if applicable):

Name of Insurance: _____ ID#: _____ Group #: _____

Name of Policy Holder: _____ Insured SS#: _____ Insured DOB: _____

Address of Policy Holder: _____ (same as patient) _____

The Westchester Medical Practice, P.C.

Privacy Practices Acknowledgement Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

(Print Name) _____

(Sign Name) _____

(Date) _____

The Westchester Medical Practice, P.C.

PAYMENT POLICY

We will file a claim to your insurance company, however, all insurance copayment and/or deductible and coinsurance amounts are due at the time of the service. Any outstanding patient balances / disallowed / uncovered amounts are due prior to your appointment.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

If you are seeing a primary care doctor from The Westchester Medical Practice, P.C., and if your insurance requires that you assign a physician as your Primary Care Physician (PCP), this must be done *prior* to your first office visit/appointment. The assignment of the PCP must be effective the day services were rendered (or beforehand).

If you have not assigned a physician from The Westchester Medical Practice as your PCP, you agree to be responsible to pay the entire balance for your visit.

If you would like to meet with the physician prior to choosing him or her as your PCP, you will have to assume full responsibility for the amount of that visit as your insurance will not cover the visit until PCP status has been assigned by you.

If you are seeing a specialist, and your insurance requires a referral or prior authorization for you to see the specialist, this must be done *prior* to your first office visit/appointment. ***If you do not bring a referral or obtain prior authorization as mandated by your insurance company, you agree to be responsible to pay the entire balance for your visit.***

I have read this agreement and understand the provisions outlined. I agree to be responsible for any balance present on my account. If my insurance denies payment because The Westchester Medical Practice is not assigned as my PCP at the time of service, I will assume full responsibility of the charges incurred for that visit, and will pay in full.

Patient Signature

Date

Print Name _____

The Westchester Medical Practice, P.C.

BENEFIT ASSIGNMENT

I HEREBY AUTHORIZE THE WESTCHESTER MEDICAL PRACTICE, P.C. to furnish information to my insurance carriers listed above concerning my illness and treatments. I hereby assign to the physician all payments for medical services rendered to me or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. This includes but is not limited to missed appointment fees, late co-pay fees, and rebilling fees. I also agree that any expense incurred by The Westchester Medical Practice, P.C. to collect any unpaid balance of the bill, including collection agencies, attorney fees, court costs, and other expenses, will be added to the bill if such additional services are required. In the event that my account is turned over for collections, information that is necessary for collection purposes will be forwarded to our professional collection company. This assignment of benefits will remain in effect until revoked by me in writing.

***** ALL RETURNED CHECKS WILL BE SUBJECT TO A \$35.00 FEE *****

Signature: _____ Date: _____

Print Name: _____

The Westchester Medical Practice, P.C.

Authorization for mail and answering machine messages

_____ I authorize the staff of WMP to leave messages on my answering machine and or to send me mail regarding appointments

_____ I **DO NOT** authorize the staff of WMP to leave messages on my answering machine and or to send me mail regarding appointments

_____ I authorize the staff of WMP to leave messages on my answering machine and or to send me mail regarding my health and test results

_____ I **DO NOT** authorize the staff of WMP to leave messages on my answering machine and or to send me mail regarding my health and test results

This authorization will remain in effect until revoked by me in writing.

Signature: _____ Date: _____

Print Name: _____

The Westchester Medical Practice, P.C.

ASSIGNMENT OF MEDICARE INSURANCE BENEFITS

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE WESTCHESTER MEDICAL PRACTICE, P.C. FOR ANY SERVICES RENDERED TO ME BY THE PHYSICIAN / SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR THE CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES FORMERLY KNOWN AS HCFA) AND ITS AGENTS AND INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. 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. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

(Print Name) _____

(Sign Name) _____

(Date) _____

IF MEDICARE IS YOUR SECONDARY INSURANCE, PLEASE CHOOSE ONE OF THE FOLLOWING:

- () You are a working aged beneficiary / or spouse is working.
- () You are disabled and under age for Medicare benefits.
- () You have end stage renal disease.
- () Other _____