ASSOCIATED MEDICAL PROFESSIONALS - **PLEASE PRINT** Today's date______________

A. PATIENT INFORMATION

Name ____
(Last) (First) (M.I.)
Address ____
(Street) (City) (State) (Zip)
Home phone__________________ Cell phone __________________ Work Phone _________________
Sex: M F DOB: _______________ Age: ____________ SS#: XXX-XX-_____________
Marital Status: S M W D
Occupation ________________________________ Employer _____________________________________
Referring physician _____________________________ Family Physician __________________________
Physicians seen regularly ____
Pharmacy Name/Location ____ Phone (____)_____________

Emergency Contact Information:
Name _______________________ Relationship ___________________________ Phone (____)_____________

B. REGARDING THE INSURED INFORMATION OR POLICY HOLDER - RESPONSIBLE PARTY INFORMATION OF DEPENDENT

Name ____
(Last) (First) (M.I.)
Address ____
(Street) (City) (State) (Zip)
Home phone___________________ Cell phone __________________ Work Phone _________________
DOB: ______________ SS#: ______________________

C. INSURANCE INFORMATION - We will need to copy your insurance cards

Primary Insurance _____________________ Insurance ID# ____________________ Group______________
Policy Holder ____ Policy Holder's DOB__________________
Policy Holder's SS# ____________________________________ Relationship to Patient _________________
Employer ____ Occupation __________________________
Secondary Insurance _____________________ Insurance ID# ____________________ Group____________

Policy Holder ____ Policy Holder's DOB__________________

Policy Holder's SS# ____________________________________ Relationship to Patient _________________

Employer ____ Occupation __________________________

PLEASE NOTIFY RECEPTIONIST IF THIS IS WORKERS COMPENSATION OR NO FAULT

ASSOCIATED MEDICAL PROFESSIONALS

AUTHORIZATION FOR RELEASE OF INFORMATION AND DIRECT PAYMENT

I hereby authorize Associated Medical Professionals to release my medical information necessary for filing claims for service carriers liable for such payments. I hereby authorize the insurance carriers to make payment of benefits directly to Associated Medical Professionals to act as my agent to help me secure payment from my insurance company. I understand that I am responsible for my bill.

Signature:____Date:_____________

Patient Name (PLEASE PRINT): ____

MEDICARE BENEFITS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information to release to the Social Security Administration or its carriers any information required to process my medical claim. I request that payment be made indefinitely to Associated Medical Professionals for services provided under the medical insurance program.

Signature:____Date:_____________

Patient Name (PLEASE PRINT): ____

YOU ARE RESPONSIBLE FOR ANY COPAYMENTS (AT TIME OF SERVICE), DEDUCTIBLES OR UNCOVERED SERVICES. PAYMENT IS EXPECTED FOR SERVICES AT THE TIME THEY ARE RENDERED. THIS OFFICE WILL SUBMIT INSURANCE CLAIMS FOR CARRIERS ONLY.

IF THE PATIENT IS A MEMBER OF ANY INSURANCE COMPANY REQUIRING A REFERRAL, SUCH AS HEALTHSOURCE, HMO CNY, A VALID REFERRAL MUST BE ON FILE WITH THIS OFFICE AT THE TIME SERVICES ARE RENDERED OR THE PATIENT WILL BE RESPONSIBLE FOR THE BILL.

THE PATIENT AGREES TO PAY ALL COLLECTION CHARGES IF IT IS NECESSARY TO PURSUE PAYMENT OF THE ACCOUNT THROUGH A COLLECTION AGENCY.

PATIENT OR PARENT'S SIGNATURE_________________________________DATE_____________

Patient Name (PLEASE PRINT): ____