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** _____