Patient Name _____

Street _____

City _____ State _____ Zip _____

Birthdate _____ Sex _____ Social Security # _____

Home or Cell Phone# _____ Work Phone _____

Emergency contact (name and number) _____

Patient's Employer _____

Employer's Address _____

Marital Status (circle one) Single Married Widowed Divorced Separated

Allergies (list reaction) _____

_____

Pharmacy preferred to be used _____

Referred by _____

Children in household:

Name(s) _____ Birthdate _____ SS# _____

_____ Birthdate _____ SS# _____

_____ Birthdate _____ SS# _____

_____ Birthdate _____ SS# _____

_____ Birthdate _____ SS# _____

**PRIMARY INSURANCE**

Insurance Company Name _____

Insurance Address _____

ID/Agreement# _____ Group# _____

Insured's Name _____ Relationship to Patient _____

Insured's Employer _____

Insured's Birthdate _____ Insurance Phone _____

**SECONDARY INSURANCE**

Insurance Company Name _____

Insurance Address _____

ID/Agreement# _____ Group# _____

Insured's Name _____ Relationship to Patient _____

Insured's Employer _____

Insured's Birthdate _____ Insurance Phone _____

**ASSIGNMENT OF BENEFITS**

I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to Dr. Alfred Poggi or Dr. Christopher Poggi.

SIGNATURE _____ DATE _____

**(OVER)**

## PAYMENT POLICIES

PAYMENT IN FULL IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of cash, credit card or check. This office does NOT accept assignment on Medicare which means paid claims are sent to Medicare for your reimbursement. However, certain exceptions may be made. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any un-met deductible, non-covered services and co-payments. In the event your insurance denies payment for services, *you will be responsible for payment*. Your signature below signifies your understanding and willingness to comply with this policy.

SIGNATURE_____ DATE_____

Initial Office Visit - $247.00 Initial Office Visit ***Medicare*** patient - $186.00
Throat Culture - $35.00 Injections - $13.00 - $50.00
**FEES FOR OFFICE VISIT AND PHYSICAL EXAMS VARY**

## MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request the payment of authorized benefits be made on my behalf. (A photocopy of these assignments shall be valid as the original.)

PATIENT NAME_____ DATE_____

PARENT/GUARDIAN SIGNATURE _____

Have you completed? (circle one)

| | | |
|---|---|---|
| Advanced Medical Directive | Yes | No |
| Durable Power of Attorney | Yes | No |
| Living Will | Yes | No |

If you do not have any of the above documents completed, please discuss this with your attorney/physician. If you wish to obtain and complete these documents, we can help you with information on how to obtain these documents.

I, _____, understand that in the event my treatment is not covered OR if reimbursement is denied by my insurance carrier, I agree to pay the physician's usual and customary fees for the medical service(s) rendered to me on the date(s) pertaining to my injury/condition.

Signature _____ Date _____

Relationship to Patient _____

## PATIENT INFORMATION RELEASE

To protect your privacy and confidentiality and the confidentiality of your medical record, this office requires a signed permission in order to release any pertinent medical information about you over the phone to anyone other than you (this includes but is not limited to; labs, x-rays, test results, appointment schedules, physician request for information, insurance and personal information.)

Refusing to sign this means that no information will be given over the phone to anyone but you.

Name_____

SIGNATURE_____ DATE_____

If you wish to have personal medical information divulged to another person, please fill in the information below.

Designee Name _____ Relationship_____

Patient Signature _____ Date_____