

PATIENT REGISTRATION FORM

New York Physicians, LLP

635 Madison Avenue
New York, NY 10022

PATIENT INFORMATION				
Name (Last, First Middle)		SS#	Birthdate	Sex
Local Address	Email			
City, State, Zip	Cell Phone:			
Home Phone	Day Phone:			
Primary Employer	Secondary Employer (if Applicable)			
Address	Address			
City, State, Zip	City, State, Zip			
Work Phone	Work Phone			
RESPONSIBLE PARTY INFORMATION (If Different than above)				
Name (Last, First Middle)		SS#	Birthdate	Sex
Local Address	Email			
City, State, Zip	Cell Phone:			
Home Phone	Day Phone:			
Relationship to Patient				
PRIMARY INSURANCE				
Name of Insurance Company		Policy #		
Name of Insured		Group #		
Address of Insurance Company		Co-Pay Amount		
City, State Zip		Deductible		
Relationship to Patient	Effective Date	Expiration Date		
SECONDARY INSURANCE (if Applicable)				
Name of Insurance Company		Policy #		
Name of Insured		Group #		
Address of Insurance Company		Co-Pay Amount		
City, State Zip		Deductible		
Relationship to Patient	Effective Date	Expiration Date		

I authorize the release of any medical information necessary to my insurer and/or CMS & its agents to process my insurance claim(s). I authorize payment of benefits directly to physicians on my behalf. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I agree to pay all charges not covered or later determined to be ineligible by my insurance carrier(s). These charges include but are not limited to deductibles, coinsurance, and copayment on my insurance policy. If the doctor is not participating with my insurance plan or I have not obtained the proper insurance referrals and authorizations, I am responsible for the bill for all services rendered.

Patient Signature

Date

NEW YORK PHYSICIANS, LLP
635 Madison Avenue
New York, NY 10022

SIGNATURE ON FILE

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to New York Physicians, LLP for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the payable for related services.

Patient Signature

Date

COMMERCIAL INSURANCE

I authorize New York Physicians, LLP to act as my agent to help obtain payment from my insurance carrier(s). This includes my authorization to release information to my insurance companies, use this form, or a copy of this form in place of the original, process all insurance submissions, and for my insurance carrier to directly reimburse New York Physicians, LLP for services rendered.

I understand that although New York Physicians, LLP will help to process insurance claims, I am responsible for my bill.

Patient Signature

Date