Steven Peskind, M.D. and Associates, P.A.

Patient Info:

Last Name___________________________________ First Name_______________________________ M.I.___________________

Date of Birth____________ Age ___________ Sex_________ Marital Status_________ Social Security #______________________

Address__________________________________ City______________________________ State________ Zip_________________

Home Ph.___________________________ Work Ph._____________________________ Cellular Ph.________________________

Email Address ____

Emergency Contact Name______________________________Ph#_______________________Relationship___________________

Parent Info. (if patient is a minor):

Last Name____________________________________ First Name_______________________________ M.I._________________

Date of Birth___________________________ Sex_________ Marital Status_________ Social Security #______________________

Address **(if different than patient):** __________________________City__________________________ State_____ Zip_________

Home Ph.____ Work Ph.____

Cellular Ph.______________________________________ Email Address____

Insurance Info: (<u>This information MUST BE COMPLETED</u>)

Primary Insurance Company Name____ **CO-PAY Amount $**_________________

Claim Address____________________________________ City________________________________ State_______ Zip_________

Insurance Customer Service Ph. #____ Group, Plan or Acct# __________________

Policy#_______________________________ **Policy Holders** Social Security # ____

Name of Policy Holder____ Date of Birth____________________________________

Policy Holder's Employer____

Employer Address_________________________________ City__________________________________ State_______ Zip________

Employer Ph. #________________________________Patient's Relationship to the Policy Holder_____________________________

WE DO NOT FILE SECONDARY INSURANCE BUT WILL BE GLAD TO PROVIDE YOU WITH THE NECESSARY INFORMATION YOU NEED TO SUBMIT TO YOUR INSURANCE COMPANY

Whom may we thank for referring you to our office? ____

Name of your "**P**rimary **C**are **P**hysician" ______________________"**P**rimary **C**are **P**hysicians" Ph. #__________________________

*******Please Read and Sign Reverse Side*******

Consent to Treat:

I give permission to the physician and whomever he may designate as his assistant(s) / associate(s) to administer such treatment as deemed necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on the findings during examination or treatment.

Authorization to Release Information:

I authorize Steven Peskind, M.D. and Associates, P.A. to release any medical information pertaining to the examination, treatment, history, prescription or medication and medical expenses of the above patient to any physician, hospital, clinic, insurance company and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility the physician may refer the patient to for medical treatment or evaluation.

Assignment of Benefits:

I authorize payment of medical benefits to Steven Peskind, M.D. and Associates, P.A., for services rendered. I understand that I am financially responsible for any copays or deductibles required by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company.

MEDICARE Limited Coverage/Waiver of Liability (Medicare patient ONLY)

Please be advised that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)1 of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Beneficiary Agreement:

I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for some services for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Record of Disclosures

The HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead. I understand that I may be contacted by any phone number that I have listed on this form.

Financial Policy:

As a courtesy to our patients, we will file insurance claims to the insurance carriers with which we participate. Any deductible or copays your insurance company requires you to pay is due at the time of service.

I understand that I am financially responsible for any copays or deductibles requires by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company. If I am covered by a Managed Care Plan that requires a referral from my Primary Care Physician (PCP), I understand that it is my responsibility to obtain the necessary referral before my appointment. If I choose to be seen by the physician, without the appropriate referral, I understand that I will be responsible for 100% of the charges incurred.

Notice to Patients of Financial Interests:

You are informed by this Notice that Dr. Peskind holds a financial interest in Presbyterian Plano Center for Diagnostics & Surgery and Pediatric Surgery Center. You have the option, at your discretion, to use an alternate health care facility.

By my signature I agree to comply with the Financial Policy, Consent to Treat Policy, Authorization to Release Information, Assignment of Benefits, Patient Record of Disclosures, and Notice to Patients of Financial Interests.

There will be a charge of $25.00 for NSF checks.

Insured or Authorized Person's Signature ____Date_________________