Sauquoit
9643 Pinnacle Road, Sauquoit, NY 13456 • Phone: (315) 737-7300 • Fax: (315) 737-7301

Utica
1418 Genesee Street, Utica, NY 13502 • Phone: (315) 797-0111 x3 • Fax: (315) 735-3459

South Utica
2709 Genesee Street, Utica, NY 13501 • Phone: (315) 737-7300 • Fax: (315) 797-1193

Patient Information

____ ___________________________ ____________________
Last Name First Name Middle Name

Date of Birth ______________________ Age ________ Referring Physician _______________________________

Your Address ____

City ____ State _________ Zip Code _____________

Home Phone ____________________________________ Work Phone ___________________________________

Social Security ______________________________ Marital Status ______________________________ Sex ______

Emergency Contact _______________________ Relationship _________________ Phone __________________

Pharmacy Name __________________________ Location ____________________ Phone __________________

Employer____________________________________ Location ____________________ Phone __________________

Responsible Party for Patient *(Guarantor)*

Name _________________________________ Relationship _________________ Phone __________________

Address ____

Insurance *(For workers' Comp, No-Fault and other Liability, also complete an Accident Information Form)*

(1) Primary Insurance____

Subscriber _________________________ Subscriber DOB_________ Relationship to Patient __________________

Policy #____ Group # _______________________________________

(2) Secondary Insurance ____

Subscriber _________________________ Subscriber DOB_________ Relationship to Patient __________________

Policy #____ Group # _______________________________________

Signatures *(Please review each paragraph below and sign where indicated)*

Assignment of Benefits

I hereby authorize payment directly to the provider of the surgical or medical benefits, if any, for his services. I realize I am responsible for non-covered services, co-payments and deductibles. I also understand that this assignment does not relieve my liability on these services.

Signature ____ Date ________________________________

Responsibilities and Cost Items

My insurance may require pre-authorization or referral for services, I understand that I may discontinue services should my insurance company deny authorization but realize that I am responsible for non-authorized services. At times I may elect to purchase cost item, including supplies and durable medical equipment, I understand that items of this nature must be paid in full at time of receipt, however I may insurance be billed for any cost items received upon payment in full.

Signature ____ Date ________________________________

Release of Information

I hereby authorize the provider to release any information acquired in the course of my treatment, including the coordination of care with other providers and the processing of insurance claims.

Signature ____ Date ________________________________

Statement to Authorize Medicare

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 about me to release to the Social Security Administration or its carriers, any information required to process my Medicare claims. I request that the payment under the Medical Insurance Program be made to the Provider for services provided to me during my lifetime.

Signature ____ Date ________________________________

Collection Fees

A collection agency or lawyer will be used on all delinquent accounts. Extra charges including but not limited to finance charges, collection agency fees, attorney fees, court costs will be added to the balance. My signature attests to my understanding of these terms.

Signature ____ Date ________________________________