Central New York Surgical Physicians, P.C.

Information & Authorization Form

☐ **New** ☐ **Updated**

Personal Information
(*Please Print)*

Patient Name ____ SS # ________-_______-_________

Address ____
street apt# /box city/state/zip

Phone (_____) _______-__________ Emergency Contact # (_____)______-__________ Name _________________

Date of Birth ____/______/______ Age _____ Occupation ____

Employer ____ Work # (_____) ____-______________

____
street apt# /box city/state/zip

Spouse/Parent Name ____

Spouse/Parent Employer _______________________________________ Work # (_____) ____-___________

Referring Physician ____Phone # (_____) ____-___________

Primary Care Physician ____

MEDICAL INSURANCE INFORMATION – PLEASE PRESENT CARD

PRIMARY INSURANCE: Name of Insurance ____________________Subscriber Name ______________________

Relationship to You ______________ Date of Birth ________________ ID # ______________ Group # ___________

SECONDARY INSURANCE: Name of Insurance ____________________Subscriber Name ___________________

Relationship to You ______________ Date of Birth ________________ ID # ______________ Group # ___________

WORKER'S COMPENSATION _____yes _____no **MOTOR VEHICLE ACCIDENT** _____yes _____no

DATE OF ACCIDENT ______________________ **DATE OF ACCIDENT** _______________________

TO OUR MEDICARE PATIENTS: STATEMENT OF AUTHORIZATION FOR PAYMENT OF MEDICARE BENEFITS.
I certify that the information by me in applying for payment under the 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 carrier, any information about me to process my Medicare claim. I request that payment under the Medical Insurance Program be made whether to me or Central New York Surgical Physicians, P.C. for services rendered to me during the period of ________ to life.

MEDICARE BENEFICIARY SIGNATURE ____________________________________**DATE** ________________

MEDICARE HEALTH INSURANCE CLAIM NUMBER ______________________**EFFECTIVE DATE** ____________

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other health plan to Central New York Surgical Physicians, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection I agree to pay all costs of collection including reasonable attorney fees.

SIGNED ____ **DATE** _____________________