Robert Feld, M.D., F.A.C.S., LLC

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NEW ❑
UPDATE ❑

PATIENT INFORMATION

Name (Last, First,MI)

Address (Street) (City) (State) (Zip)

Home Phone | Social Security Number

Date of Birth | Sex: MALE ❑ FEMALE ❑ | Status: ❑ SINGLE ❑ MARRIED ❑ WIDOW ❑ DIVORCED ❑ SEPARATED

Employer | Business Phone / Fax

Address (Street, City, State, Zip)

In Case of Emergency Contact | Relationship: ❑ SPOUSE ❑ PARENT ❑ OTHER | Phone

BILLING INFORMATION

Name | Relationship: ❑ SPOUSE ❑ PARENT ❑ OTHER

Address (Street, City, State, Zip)

Home Phone | Social Security Number

Date of Birth | Sex: MALE ❑ FEMALE ❑

Employer | Business Phone / Fax

Address (Street, City, State, Zip)

INSURANCE INFORMATION (As It Appears On Your Insurance I.D. Card/Form)

NAME OF COMPANY	POLICY HOLDER	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	CO-PAY	ANNUAL DEDUCTIBLE

Assignment & Release: I authorize the release of medical information necessary to process claims. I authorize insurance benefits to be paid directly to the physician, I guarantee payment of all copays and deductibles not paid by my insurance carrier.

Signature | Date

CLAIMS AUTHORIZATION FOR MEDICARE, MANAGED HEALTH AND OTHER COMMERCIAL CARRIERS

MEDICARE.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and the Social Security Administration and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

MANAGED CARE CARRIER

I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any or dependent for purposes of review, investigation or evaluation of any claim submitted to your Managed Care Carrier.

I also authorize my Managed Care Carrier to disclose to a hospital or health care service plan, self-insurer or any insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my Managed Care Carrier including a reasonable time thereafter until its final consummation. This authorization shall be binding upon me, my dependents and our heirs executors and administrators.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.