

SOUTHERN WESTCHESTER ORTHOPEDICS & SPORTS MEDICINE ASSOCIATES, P.C.
970 NORTH BROADWAY, SUITE 204
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INSURANCE INFORMATION

PATIENT'S NAME: _____

NAME OF PRIMARY INSURANCE COMPANY: _____

INSURANCE IDENTIFICATION NUMBER _____

POLICYHOLDER _____ SOC. SEC. # _____ DATE OF BIRTH _____

IS THIS POLICY AN: HMO _____ PPO _____ POS _____

ADDRESS OF INSURANCE COMPANY _____

NAME OF SECONDARY INSURANCE COMPANY: _____

INSURANCE IDENTIFICATION NUMBER _____

POLICYHOLDER _____ SOC. SEC. # _____ DATE OF BIRTH _____

IS THIS POLICY AN: HMO _____ PPO _____ POS _____

ADDRESS OF INSURANCE COMPANY _____

PLEASE NOTE: If you register as a private patient and later want your case converted to a Workers' Compensation Claim or a No Fault Claim there will be a \$350.00 fee to you for all of the administrative work involved.

*****EFFECTIVE: JANUARY 1ST, 2012*****

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF THE CO-PAYMENT IS NOT PAID AT THE TIME OF SERVICE AN ADDITIONAL ADMINISTRATIVE FEE OF \$15.00 WILL BE APPLIED TO YOUR ACCOUNT.

*****EFFECTIVE: JANUARY 1ST, 2012*****

AN ADMINISTRATIVE FEE OF \$10.00 WILL BE CHARGED FOR ANY DISABILITY/MEDICAL FORMS FILLED OUT BY THIS OFFICE. PAYMENT IS DUE UPON RECEIPT OF THE FORM.

I certify that the above information is correct to the best of my knowledge. I, the undersigned certify that I have insurance coverage with _____ and assign directly to Southern Westchester Orthopedics & Sports Medicine Assoc., P.C. all insurance benefits. I further understand that I will be responsible for any charges that are not covered by my insurance company. I also authorize release of any medical information to my Primary Care Physician and/or insurance company. I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

SIGNATURE _____ DATE _____