Raisa Mitelman, MD

Allay Medical Care

PATIENT INFORMATION

Name _____ Soc. Sec.# _____
(Last Name) (First Name) (Initial)

Address _____ City _____

State _____ Zip _____ Home Phone # _____ Daytime Phone # _____

Sex M F Age _____ Birth date _____ Single Married Widowed Divorced

Employer _____ Occupation _____

Business Address _____ Business Phone # _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ _____ Tel # _____
(Relationship)

NSURANCE INFORMATION

Primary Insurance _____ Subscriber Name _____

ID # _____ Group # _____

Medicare ID# _____ Medicaid ID# _____

Secondary Insurance _____ Subscriber Name _____

ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(Name of Insured) (Name of Insurance)

to pay and hereby assign directly to Dr. RAISA MITELMAN all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred, whether or not paid by insurance.

I further acknowledge that my insurance benefits, when received by and paid to Dr. RAISA MITELMAN, will be credited to my account, in accordance with the above assignment.

_____ _____
Authorized Signature of Subscriber Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. RAISA MITELMAN for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Allay Medical Care, PC
7 Lexington Ave. Suite 1A
New York, NY, 10010

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Allay Medical PC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Allay Medical PC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Allay Medical PC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature Date