Carroll Gardens Podiatry

398 Court Street
Brooklyn,NY 11231
718-834-0909

Date______________________________

Name____

Home Address____

City________________________ **State**____________________ **Zip Code**__________________________

Home Phone_______________________ **Birthdate**___________________ **Age**_____________________

Email Address ____

Male ☐ **Female** ☐ **Single** ☐ **Married**☐ **Widowed** ☐ **Separated**☐ **Divorced** ☐

Responsible Party______________________ **Relationship to Patient**__________________________________

Employer ____________________ **Occupation**____________ **Work Phone**____________________________

Patient Social Security#_____________________ **Subscribers Social Security #**____________________________

Primary Insurance____

Subscriber#_____________________________________ **Group#**_________________________________

Secondary Insurance____

Subscriber#_____________________________________ **Group #**________________________________

Emergency Contact__________________________________ **Phone#**_______________________________

Primary Care Physician Name __________________________ **Phone #** ____________________________

Reason For Todays Visit? ___________________________________ ______________________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. John Pace, for any services furnished me by that physicianI 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 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature____ **date**__________

I the undersigned have insurance coverage with______________________ ***and assign directly to Dr. John Pace. All medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.***

Signature____ **date**_________