LANCE BERLIN, D.P.M., P.C. Podiatric Medicine and Surgery
Union Medical Plaza, 2330 Union Boulevard, Islip, NY 11751
Phone: 631-277-8900 Fax: 631-277-0298 Web: www.lanceberlin.com

CONFIDENTIAL PATIENT INFORMATION

TODAY'S DATE: ______________

LAST NAME: ________________________________ FIRST NAME: ______________________________________

BIRTHDATE: ________________________ AGE: ________ MARITAL STATUS: ________________

HOME ADDRESS: ____

CITY: ___________________________________ STATE: ________________ ZIP CODE: __________________

HOME PHONE #: (_____) ________________________ WORK PHONE #: (_____) _______________________

PATIENT'S SOCIAL SECURITY#: ____

EMPLOYER'S NAME / ADDRESS: ____

CITY: ___________________________________ STATE: ________________ ZIP CODE: __________________

EMERGENCY CONTACT'S NAME: _____________________________ PHONE #: (_____) ___________________

INSURANCE INFORMATION

Please note, if your insurance company requires you to bring a referral and you do not have a referral for your office visit, you will be required to make payment at the time of your visit.

PRIMARY INSURANCE: _____________________________ POLICY HOLDER: ____________________________

IDENTIFICATION No.: _______________________________ GROUP No. (IF ANY): ________________________

EFFECTIVE DATE: _______________________

SECONDARY INSURANCE: ___________________________ POLICY HOLDER: ____________________________

IDENTIFICATION No.: _______________________________ GROUP No. (IF ANY): _______________________

EFFECTIVE DATE: _______________________

INSURED'S NAME: ____ BIRTHDATE: _________________________

INSURED'S SOCIAL SECURITY #: _________________________ WORK PHONE #: (______)_________________

INSURED'S EMPLOYER/ADDRESS: ____

WORKER'S COMP.: ___ YES ___ NO

INSURANCE CARRIER: ________________________

____

WCB #: ______________________________________

CARRIER CASE #: ______________________________

DATE OF INJURY: ________________

NO FAULT: ___ YES ___ NO

INSURANCE CARRIER: _________________________

____

CLAIM #: _____________________________________

POLICY #: ____________________________________

DATE OF INJURY: ________________

MEDICAL HISTORY

Who is your medical doctor? ____

Are you a diabetic? ___Yes* ___No

*If yes, who is your medical doctor treating you for this condition? _______________________________

*When did you last see your medical doctor for this condition? ________________________________

Please list any allergies that you may have: ____

What is your chief complaint for today's visit? ____

Who referred you to this office? ____

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I have received and reviewed, or have been offered and declined Lance Berlin, D.P.M, P.C. notice of privacy practices. Should I have any questions regarding the notice of privacy practices, I understand that I can contact this office at 631-277-8900.

PATIENT'S SIGNATURE_________________________________ **DATE:** ____________________________

I hereby authorize Lance Berlin, D.P.M. to release any medical information necessary to process claims. I hereby assign to the physician all payments for medical services for any amount not covered by insurance.

Claim Authorization – Medicare

I request that payment of authorized Medicare benefits be made to the treating physician for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the health care financing administration, and its agents, any information needed to determine the benefits payable to related services.

In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Authorization for Other Carriers

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

I also authorize disclosure to a hospital or health care service plan 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 the 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 coverage, including a reasonable time thereafter, until its final consumation. This authorization shall be binding upon me, my dependents, heirs, and executors.

Payment

Medicare will only pay for the services that it deems reasonable and necessary under section 1862 (a) (1) of the medical bylaw. By signing below; if Medicare denies payment, you agree to be personally responsible for payment.

PATIENT'S SIGNATURE: _________________________________ **DATE:** ____________________________

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NOTICE TO OUR PATIENTS

Although we participate in many insurance plans, it is impossible for our office to know the rules and regulations of each plan.

It is your responsibility to know the limits and requirements of your particular plan. (This includes necessity for referrals, covered and non-covered services, etc.) If you do not understand your coverage, we suggest you contact your insurance company.

Payment, including co-pay, is expected at the time of your visit. (Please note there will be a $25 charge for all returned checks.)

The daily schedule is well planned so that we may accommodate all our patients' needs. If you are unable to keep your scheduled appointment we ask that you inform the office at least 24 hours in advance. There will be a $25 fee for missed appointments.

I authorize the office of Dr. Lance Berlin to release to my health insurer, and its agents, the information that is essential for the determination of benefits payable for related services. I authorize the payment of insurance benefits to be made on my behalf to this office. **If I have no insurance or this office does not participate with my insurance, I understand that I am responsible for payment in full at the time of my office visit.**

I have read and understand the preceding information.

SIGNATURE_____________________________________ **DATE:** ______________