PATIENT REGISTRATION
&
AUTHORIZATION FOR TREATMENT

Please print all information legibly.

Name:_____ Date Of Birth:_____

Address:_____
(Street) (City/State/Zip)
Phone: Home_____Cell_____
Marital Status: Married <> Single <> Divorced <> Widow<>

Social Security #_____

Primary Insurance:_____ Policy #_____

Secondary Insurance:_____ Policy #_____

Responsible Party Name:_____ Phone #_____
Relationship:_____Address:_____
Pharmacy Name & Phone # _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION FOR TREATMENT

I hereby authorize treatment and authorize the provider of medical services to release information for those services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. **I understand that I am financially responsible for all charges not covered by my insurance.**

_____
(Patient or Responsible Party) (Date)

Provider Name: Edid G. Ramos-Rivas, M.D.

INSURANCE AUTHORIZATION

Provider Name: Edid G. Ramos-Rivas, M.D.

I authorize the release of any medical information necessary to process claims.

I authorize payments under my insurance programs to be made directly to the above provider for any services furnished to me.

This authorization also permits the release of information by HCFA (its intermediaries or carriers) on any UNASSIGNED Medicare claims to the above.

I further permit copies of this authorization to be used in place of the original.

_____ _____
(Date) (Signature of Patient or Responsible Party)

_____
(Print Name of Patient or Responsible Party)