

Legal Name _____ Preferred Name _____
DOB _____ Marital Status: Single Married Separated Divorced
SS# _____ E-Mail _____
Address _____ Home Phone _____
City _____ ST _____ Zip _____ Cell Phone _____
Employer _____ Occupation _____
Address _____ Work Phone _____
City _____ ST _____ ZIP _____ Referred By _____
Primary Physician _____ PCP Phone _____

Spouse/Parent Name _____
DOB _____ SS# _____
Employer _____ Occupation _____
Address _____
City _____ ST _____ ZIP _____ Work Phone _____

Primary Insurance _____ Name of Insured _____
Insurance address _____ DOB _____
City _____ ST _____ ZIP _____ Phone _____
ID#/SS# _____ Group _____

Secondary Insurance _____ Name of Insured _____
Insurance address _____ DOB _____
City _____ ST _____ ZIP _____ Phone _____
ID#/SS# _____ Group _____

Emergency Contact _____ Relationship _____
City _____ ST _____ Zip _____ Phone _____

Pharmacy Location _____ Phone _____

I assign all medical/surgical benefits to which I am entitled to attending physician. I authorized the release of medical information necessary to request reimbursement from insurance companies. This assignment will remain effect until revoked by me in writing. A photocopy of this assignment is to considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Consent to receive treatment: I hereby authorize the physician to treat myself or if a minor, my daughter, as deemed medically necessary.

Signature: _____ Date: _____

Authorization to Release Patient Information

I authorize Joseph K. Leveno, MD and staff to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by physicians or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies or other governmental or third payers, or any organizations contracting with any of the above entities to perform such functions.

I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

I also give my authorization for Joseph K. Leveno, MD and staff to discuss my financial data and all medical information with the following people:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

These authorizations will remain in effect permanently or until written notice otherwise.

Patient's and/or Guardian Signature: _____

Date: _____

Patient's Responsibility

Signing of this form in no way implies that your insurance company will cover your visits with this office. Joseph K. Leveno, MD and their employees cannot guarantee any information given to us by your insurance carrier regarding your benefits.

1. If you are not part of an HMO, PPO, Medicare/Medicaid, Managed Choice Plan that your physician participates in, you will be responsible for your bill at the time of service.
2. If you are part of a PPO plan and you have a deductible for services other than your regular office copay, you will be responsible for payment of said deductible.
3. If you are part of a managed choice, HMO plan, or Tricare Prime failure to obtain a valid referral from your Primary care Physician/Manager (PCP or PCM) may result in no benefits being paid. You will be responsible for any non-payment from your insurance carrier.

Patient's and/or Guardian Signature: _____

Date: _____