

PATIENT REGISTRATION FORM

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I hereby authorize the physicians of PLOTSKY MEDICAL ASSOCIATES, P.C. to apply for benefits of covered services rendered by this office and request that the payments from Medicare and/or all other insurance companies to be made directly to them.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any necessary information for all related claims to Medicare and/or all other insurance companies.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. If Medicare and/or any other insurance denies payment, I agree to be personally responsible for the balance of my account for any professional services rendered.

Signature _____ Date _____

NAME _____ DOB _____ SEX _____

HOME ADDRESS _____

CITY, STATE, ZIP _____

SSN _____ PHONE _____ WORK PHONE _____ EXT _____

CELL PHONE _____ EMAIL _____

EMPLOYER _____ REFERRED BY _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

SPOUSE _____ WORK PHONE _____ EXT _____

INSURANCE CARRIER _____ ID# _____ GROUP # _____

CARDHOLDER NAME _____ RELATIONSHIP _____

CARDHOLDER DOB _____ CARDHOLDER SSN _____

24 Hour notice is required for appointment cancellations. There will be a \$25.00 charge for all routine appointments and a \$50.00 charge for all physical appointments that are not cancelled in advance. (This includes appointments that are made the same day.)

