

PATIENT INFORMATION: **Dr Mullins** **Dr Palumbo** **Dr McCormick** **Dr Darakchiev** **Dr. Reid** (Circle one)

Name _____ Date of Birth ____/____/____ Age _____ M / F

Address _____

City, State _____ Zip _____ S.S. # _____ - _____ - _____

Home # _____ Emergency # _____ Name of Contact _____

Work # _____ CELL # _____ Marital Status S / M / W / D / SEP

Referring Doctor Name _____ Telephone# _____

Referring Doctor Address _____

Primary Care Physician _____ Telephone # _____

INSURANCE INFORMATION **If Change of Insurance / effective DATE** _____

Primary Insurance _____ Policy # _____ Policy Holder _____

Insurance Address _____ Copay Amount _____

Insurance Phone Number _____ Policy Holder SS# _____ Policy Holder/ DOB _____

Relationship to Patient: _____ Employer _____

Secondary Insurance _____ Policy # _____ Policy Holder _____

Insurance Address _____

Insurance Phon _____ Policy Holder SS# _____

Policy Holder/ Date of Birth _____ Relationship to Patient: _____

WORKERS COMPENSATION or NO FAULT

Insurance Carrier _____ Claim Number _____

Carrier Address _____

Date of Injury/Accident _____ Case Mgr _____ Phone _____

Employer _____ Employer Address _____

Specific body part Injured _____ How did injury occur _____

Assignment and Release

I, the undersigned, have insurance coverage and assign directly to Dr. Kevin J. Mullins, M.D. , Salvatore J. Palumbo M.D, William E. McCormick MD, Borimir J. Darakchiev, MD and Patrick J. Reid, MD 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 my insurance carrier. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the below signature on all of my insurance submissions. Furthermore, I authorize the release of my medical information to any other medical facility / and or Doctors office taking part in my care. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Kevin J. Mullins MD, / Dr. Salvatore J. Palumbo M.D., William E. McCormick MD, Borimir J. Darakchiev, MD and Patrick J Reid, MD for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and the Social Security 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 on my medical claim, my signature authorizes releasing of the information to the insurer or agency listed. 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, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient / Guardian

Date