I assign and authorize insurance benefits to be paid directly to Dr. Robert M. Rosen. I also understand that I am financially responsible for any balance due. I authorize release of medical information to my insurance company and other medical providers involved in my care. All co-payments, deductibles and non-covered services are due at the time of service. All cosmetic procedures are to be paid at the time of service. It is the responsibility of the patient to understand their individual policy. Appointments must be cancelled 24 hours in advance. All non-cancelled appointments may be subject to charge.

Signature_____ **Date**: _____/_____/_____

Please give this form , your insurance cards and driver's license to the receptionist.

Do you give our office permission to discuss your medical information with family members?
●YES ●NO If yes, please provide their name and phone number.

Name:_____ **Relationship**_____
Phone #: Home (_____) _____-_____ Cell: (_____) _____-_____

May we leave personal medical information on your answering machine at home? ●YES ●NO
May we e-mail personal medical information to you? ●YES ●NO

Signature:_____ **Date:**_____/_____/_____

FOR MEDICARE PATIENTS: This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____
Signature as it appears on Medicare Card ***Date***

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services

_____ _____/_____/_____
Signature as it appears on Medigap Card ***Date***

PATIENT INFORMATION

Date_____

Patient Name_____, _____, _____
Last *First* *MI*

Address_____ **Home # (**_____**)** _____ **-**_____

City_____ **State**_____ **ZIP**_____ **Cell #: (**_____**)** _____ **-**_____

DOB _____**/**_____**/**_____ **Age:** _____ **Sex:** **M** **F** **SS# of PATIENT** _____**-** _____ **-**_____

******** EMAIL *IMPORTANT*** _____@_____._____
FOR APPOINTMENT REMINDERS AND WEATHER RELATED CLOSING ONLY

Occupation:_____ **Work # (**_____**)**_ _____**-**_____

Employer Name/Address_____

Please Circle: *Single Married Divorced Widowed Domestic Partner* **Pharmacy Name and Phone #:**_____

Responsible Party Name and Address_____

Emergency Contact Name _____ **#: (** **)** _____ **-** _____

Primary Care Physician_____ **Referred by :**_____

PRMARY INSURANCE INFORMATION

Insurance ID#: _____ **Group #:** _____ **Insurance Carrier**_____

Policy Holder Circle: Self Spouse Parent Name (if different from SELF)_____

SS # of PRIMARY Insured : _____**-**_____**-**_____ **Policy Holder Birth Date (if different from PATIENT)** _____**/**_____**/**_____
Does your insurance require a referral or pre-authorization? ● **YES** ● **NO** **Co-Pay $**_____

SECONDARY INSURANCE INFORMATION

Insurance ID #:_____**Group #:** _____**Insurance Carrier**_____

Policy Holder Circle : Self Spouse Parent Name (if different from SELF)_____

SS # of Primary Insured: _____**-** _____**-**_____ **Policy Holder Birth Date (if different from PATIENT)**_____**/**_____**/**_____
Does your insurance require a referral or pre-authorization? ● **YES** ● **NO** **Co-Pay $**_____