WELCOME TO OUR PRACTICE

Thank You for selecting our practice! We will strive to provide you with the best possible healthcare. To help us meet your entire healthcare needs, please fill out this form completely in ink.

May we leave a message? **Home:** YES ❑ or NO ❑ **Work:** YES ❑ or NO ❑ **Cell:** YES ❑ or NO ❑ **Email:** YES ❑ or NO ❑

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	Maiden Name:	Marital status (circle one) Single / Married / Other

Birth date: / /	Age:	Cell phone #: ( )	Email address:	Pharmacy:	Pharmacy #:

Street address:	Social Security #: - -	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #: ( )

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicated primary insurance:

Subscriber's name:	Subscriber's S.S. #: - -	Birth date: / /	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

SPOUSE'S INFORMATION ❑NOSPOUSE

Spouse's last name: First name: Middle:	Birth date: / /	Social Security #: - -

Employer Name:	Employer Address:	Employer phone #: ( )	Email:	Cell phone #: ( )

I certify that I have read and understand the above information the best of my knowledge. The above questions have been answered accurately. 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. I authorize payment of medical benefits to Andrew F. Rubenstein, M.D., P.C, when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize Andrew F. Rubenstein, M.D., P.C. to use or disclose any information for treatment, payment and health care operations. I authorize that the physician/and or employees of Andrew F. Rubenstein, M.D., P.C. can contact me via electronic formats (i.e. telephone, e-mail, fax, ect) or leave me a message if they are unable to contact me directly. I have read or received a copy of the Notice of Privacy Practices.

Patient/ Guardian Signature:	Date:

Financial Policy Notice

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

Insurance payments are based on rates that insurance companies arbitrarily determine to be usual and customary. Often times, insurance payments are not 100% of the fees charged. It is your responsibility as the patient to know your insurance coverage benefits and for paying any amount not cover by insurance. All co-payments, co-insurance and deductible amount are due and payable at the time services rendered. If your account becomes delinquent, you will be responsible for any and all collection expenses, interest (1.5% per month) and legally allowed fees including, but not limited to court costs, legal fees and penalties.

It is understood that the temporary financial problems arise; you are encouraged to contact us promptly for assistance in the management of your account. If you have any questions regarding the information, please do not hesitate to ask.

I have read the above and agree to this office policy. _____
(Please Initial)

Cancellation Policy Notice

Andrew F. Rubenstein, M.D., P.C.'s understands that personal situations arise and you need to cancel your appointment. We kindly request a 24 hour notice of cancellation. Not showing for an appointment or falling to courteously notify our office prevents us from seeing other patients who have sudden medical problems which require medical intervention. If you are running late to a scheduled appointment, please contact our office as soon as possible. The staff will assess the situation to try and accommodate. Keep in mind, the appointment may need to be delayed or rescheduled.

I have read the above and agree to this office policy. _____
(Please Initial)

Consent for General Patient Care and Assignment of Benefits

I have read the above policies and understand my responsibilities as a patient. I herby authorize Andrew F. Rubenstein, M.D., P.C., including physicians and employees, to provide medical care to me and agree to pay all fees and charges for such treatment. I authorize Andrew F. Rubenstein, M.D. P. C., to furnish all information, including protected health information, to insurance carriers and other health care providers concerning my illness and treatments, and assign all payments for medical services rendered to be made directly to Andrew. F. Rubenstein, M.D., P.C.

Patient Signature: _____ Date: ___/___/_____

Consent to Treat a Minor (only if applicable)

I, _____, give Andrew F. Rubenstein, M.D., P.C. my permission to examine and treat_____.
(Parent/Guardian) (Minor)

Authorization to treat minor: _____
(Mother, Father, Guardian signature)