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1223-B MONTAUK HIGHWAY
OAKDALE, NEW YORK 11769

PATIENT REGISTRATION

PATIENT NAME: First Last M.			DOB	AGE	MARITAL STATUS **S M D W**
HOME ADDRESS	CITY	STATE	ZIP CODE		
EMAIL ADDRESS	RACE	ETHNICITY	LANGUAGE		
OCCUPATION	SOCIAL SECURITY NO.	CELL PHONE	HOME PHONE		
EMPLOYER	ADDRESS	WORK PHONE			
SPOUSE (OR PARENT)	SPOUSE (OR PARENT) EMPLOYER	SPOUSE (OR PARENT) WORK PHONE			
PRIMARY CARE PHYSICIAN	ADDRESS	TELEPHONE			
PHARMACY	ADDRESS	TELEPHONE			

BILLING AND INSURANCE INFORMATION

SEND BILL TO	First Last M.		RELATIONSHIP TO PATIENT	
	EMPLOYER	WORK PHONE	HOME PHONE	
PRIMARY INSRUANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE	
	INSURANCE COMPANY ADDRESS	POLICYHOLDER'S SOCIAL SECURITY	DATE EFFECTIVE	
	POLICYHOLDER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
	POLICYHOLDER'S ADDRESS	WORK PHONE	POLICYHOLDER'S DOB	
SECONDARY INSRUANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE	
	INSURANCE COMPANY ADDRESS	POLICYHOLDER'S SOCIAL SECURITY	DATE EFFECTIVE	
	POLICYHOLDER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
	POLICYHOLDER'S ADDRESS	WORK PHONE	POLICYHOLDER'S DOB	

BILLING POLICY AND PATIENT AUTHORIZATION

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, or credit card. Please note that if your account remains unpaid for a period of 90 days, your account may be placed with Hamilton Law Group, PC for collection. You will be responsible for interest of 1.5% per month (18% per year), and for collection attorney's fees of 40% on the unpaid balance and interest.

I, the patient named above, hereby authorize Gary S. Kasten, D.O., F.A.C.O.G to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing-agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care.

As the patient or parent or guardian, I agree to the above terms and conditions.

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Date: Signature of Patient or Parent or Guardian Last Updated: 2/2/2016