breastlink of NEW YORK

Breastlink Patient Registration

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____State: _____ Zip: _____

Home Ph: ( ) _____ Cell Ph: ( ) _____ Wk Ph: ( ) _____

Email address: _____

Gender: ____Female ____ Male Breastfeeding: [ ] Yes [ ] No

Name of Referring Provider: _____Phone Number: _____

Address of Referring Provider: _____City: _____State: _____ Zip: _____

PCP Name (if different from above): _____ Office Ph: ( ) _____

PCP Office Address: _____City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Occupation: _____ Marital Status (circle one): Single Married Divorced Widowed

How did you hear about us? [ ] Website [ ] Friend [ ] Family member [ ] Referring MD: Name: _____

Address: _____

_____

Insurance Guarantor Information:
Name of Insurance Subscriber: _____ Date of Birth: _____Relation to Patient: _____

Phone Number: ( ) _____

Primary Insurance Information:
Insurance Company: _____ Phone Number: _____ Policy #: _____

Group Number: _____ Effective Date: _____ Specialist Co-pay amount (if applicable): $ _____

Insurance billing address: _____City: _____ State: _____ Zip: _____

Secondary Insurance Information:
Insurance Company: _____ Phone Number: _____ Policy#: _____

Group Number: _____ Effective Date: _____Specialist Co-pay amount (if applicable): $_____

Insurance billing address: _____City: _____ State: _____ Zip: _____

Pharmacy Information:
Pharmacy Name: _____ Phone Number: _____

Address: _____

Authorization for Assignment of Benefits: By my signature below, I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company). Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, that I am fully responsible for all charges/services provided at my appointment and payment is due at the time of service.

Authorization and Consent for Medical Care/Treatment: By my signature below, I hereby authorize Breastlink to furnish the necessary medical treatment or procedures including but not limited to laboratory procedures, chemotherapy agent or such drugs, surgical procedures, and supplies as ordered by the attending physicians), his assistants, or designees. I further recognize that the physicians who practice at Breastlink may not be employees or agents of Breastlink but independent physicians. Breastlink contracts with these physicians for services normally provided and questions relating to care that my physician has given or ordered should be addressed to him/her.

Lifetime Medicare B Signature Authorization: By my signature below, I authorize my holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of Breastlink and 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 benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for the deductible and co-insurance.

Patient Signature: _____ Date: _____