

REGISTRATION

DR. RUTH ABRAMOVITZ, M.D.
DR. CARLOS GAMBIRAZIO, M.D.
1415 SALEM STREET, STE. 207
LAFAYETTE, IN 47904

Date _____

Home Phone _____

Date of Birth _____

Cell Phone _____

Patient Name _____
Last First Middle

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Age _____ Marital Status _____

Race _____ Sex Male Female

Emergency Contact _____ Relationship _____ Phone _____

Patient Employed By _____ Occupation _____

Business Address _____ Phone _____

May we contact you at work yes no

Spouse's Name (or responsible party if minor) _____ Spouse's Social Security # _____

Spouse's Occupation _____ Business Phone _____

Spouse's Employer _____ Address _____

Spouse's Date of Birth _____

Do you have medical insurance? Yes No If yes, Name of Primary Insurer _____

What is your co-pay, if any? _____ Deductible _____ Co-insurance _____

Name of Secondary insurer (if any) _____

How did you learn of our practice? _____

ASSIGNMENT & RELEASE OF INSURANCE

I, the undersigned, have insurance coverage with _____ and assign directly to Lafayette
Name of Insurance Company

Internal Medicine 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submissions.

Signature of Insured or Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lafayette Internal Medicine for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-2500 form, or elsewhere on other approved claim forms or electronically, submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge and determination of the Medicare carrier.

Signature

Date