Assignment Of Insurance Benefits
and Authorization For Release Of Health Service Or Treatment Information.

I hereby authorize and direct you, my insurance company, to pay directly to Neofitos Stefanides, Physician, P.C. such sums as may be due and owing this office for services rendered me. I understand that insurance billing is a service provided as a courtesy and that I am at all times responsible for any fee not paid by my insurance carrier. In the event that a claim is submitted on my behalf, and the reimbursement check for these services comes directly to me, I agree to sign it and endorse the back to read "Pay To The Order Of Neofitos Stefanides, Physician, P.C.., and to personally present the check to the office within five(5) working days of it's receipt.

In the event my insurance company refuses to make payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that this is an irrevocable and direct assignment of the benefits of my insurance policy.

A photocopy of this assignment shall be considered as effective and valid as the original for any current or successive services. I also authorize release of any information pertinent to my claim to any insurance company, adjuster or attorneys involved in collection or settlement of my account.

This agreement has been explained to my full satisfaction.

Patient Print Name: _____

Patient Signature: _____ Date: _____

I _____ certify and affirm that the condition for which I have sought treatment **is not the result of a work or auto related injury**.

I further attest that I am not eligible for, or seeking Workers Compensation benefits for said condition.

I am entitled under the terms of my policy with to benefits for the treatment being rendered, and expect that my claims will be processed appropriately without delay.

Signed: _____

Print: _____

Witness: _____

Non Assignment Policy

You and your family are covered for medical care.

Your insurance company refuses to honor your right to assign your benefits to us. This means that they would rather you pay us up front and wait for your checks to come.

We believe this makes it difficult for you to get care in this office, and developed this policy to make it possible for you and your family to receive care without worry.

Please choose one of the options below:

☐ You may pay our fee (including deductible) as services are rendered and keep the insurance checks when they come to you.

☐ You may pay only your visit Co-Payment (after deductible) each time you come (if applicable) and then present the insurance checks to the office when you receive them.

If you selected option 2, please **read** and sign the following terms:

I _____, hereby agree to present, in a timely fashion, reimbursement checks which are for services rendered in this office. I further agree to seek written and or verbal explanation on behalf of and to the satisfaction of this office in the event that payment is not received within 60 days of the date of service. I acknowledge that breech of these terms will result in the rendering of this agreement null and void and agree in that event to pay immediately all sums due for unpaid services, including the cost of all means undertaken to collect said sums from the time of the breach.

Furthermore, I agree to pay an additional sum of not less than $250.00 in the event that it becomes necessary for Neofitos Stefanides, Physician, P.C or any of its employees or representatives to take any action to collect any portion of my outstanding balance in this office.

_____ _____ _____

Patient Signature Date Witness

PATIENT REGISTRATION FORM

Please fill out completely

Mr./Ms./Mrs. (Please circle one)

Name: _____ _____ / _____ / ____
First Middle Last Date of Birth

Home Address: _____ _____
Street Social Security No.

_____ Sex (please circle): M F
City State Zip Code

Home Phone: _____ Work Phone: _____

Cell: _____ E-mail: _____

Employer's Name, Address & phone#: _____

Occupation: _____

Referred By: _____ Primary Care Dr.: _____

Referring Dr. Phone #: _____ Primary Care Dr. Phone #: _____

Part of Body Injured: _____ Date of Injury/First Symptom: _____

How were you injured?: _____

Have x-rays been taken
within the past 6 months? Yes___ No___ If yes, where: _____
Name City State

Emergency Contact: _____ Phone: _____

We require cash payment on the day you are treated, if you are not covered by a current health insurance policy. If you are a member of a health maintenance organization (HMO) or a preferred physician organization (PPO), please give us your insurance card to copy for our files.

WE REQUIRE CO-PAYMENT ON THE DAY YOU ARE TREATED

Insurance Company: _____ Group #:_____

Insurance Company Address: _____

Name of Insured: _____ Insured SS#: _____

Relationship to Patient: _____ If Applicable, Medicare #: _____

Secondary Insurance Co.: _____

Secondary Insurance ID#: _____

Signature: _____ Date: _____