

Adult Medicine & Pain Management

1 Pinnacle Place, Ste. 203, Albany, NY 12203
Phone: 518-438-4700, Fax: 518-438-3190

General Consent To Medical Services

Fill out before your first Adult Medicine Appointment, or if you are returning after two or more years of absence

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I authorize Suzanna Boka, MD to administer necessary treatment, and perform medically indicated procedures for me, dictated by the diagnostic findings. I also consent to the exchange of my medical information with other healthcare professionals involved in my care as necessary.

FINANCIAL AGREEMENT

I accept financial responsibility for services and charges including co-payments, deductibles, co-insurance, charges resulting from terminated insurance, services not covered by my insurance and collectable balances allowed by insurance companies after processing my claim. I accept financial responsibility for services not covered due to absence of authorization/referrals that I am obligated to obtain under my health benefit plan. I agree to provide correct and current insurance and demographic information at the time of my visit to facilitate insurance processing. I accept full consequences of any inaccuracies in demographic or insurance information provided by me that might have a negative impact on reimbursement of my visits or on my medical care. I acknowledge that my co-payment, or any deductibles will be collected at the time of my visit.

MISSED APPOINTMENT

Our office requires 24 hours notice to cancel an appointment. You will be charged a \$25.00 no-show fee if you do not give this 24 hour notice.

RELEASE MEDICAL AND BILLING INFORMATION

I also authorize Adult Medicine, PC/Pain Management Services to release my medical and billing information to governmental agencies, insurance carriers or their agents who are responsible for the reimbursement of my care.

MEDICARE AUTHORIZATION AND ASSIGNMENT

I the undersigned certify that the information provided by me to apply for payment under title XVII(Medicare) of Social Security Act is true and correct. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits of the benefits payable to related services. I requested payment of authorized Medicare benefits be made on my behalf to Adult Medicine PC/Pain Management Services.

Signature of Patient/Authorized Persons: _____ Date: _____

Witness: _____ Date: _____

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