SOUTHERN WESTCHESTER ORTHOPEDIC & SPORTS MEDICINE ASSOCIATES, P.C.
970 NORTH BROADWAY, SUITE 204
YONKERS, NEW YORK 10701
TELEPHONE: (914) 476-4343

DAVID E. LENT, M.D., F.A.A.O.S.
ERIC M. SPENCER, M.D.

INSURANCE INFORMATION

PATIENT'S NAME: ______________________________

NAME OF PRIMARY INSURANCE COMPANY: ______________________________

INSURANCE IDENTIFICATION NUMBER ______________________________

POLICYHOLDER______________ SOC. SEC. #______________ DATE OF BIRTH ______________

IS THIS POLICY AN: HMO ______________ PPO ______________ POS ______________

ADDRESS OF INSURANCE COMPANY______________________________

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NAME OF SECONDARY INSURANCE COMPANY: ______________________________

INSURANCE IDENTIFICATION NUMBER ______________________________

POLICYHOLDER______________ SOC. SEC. #______________ DATE OF BIRTH ______________

IS THIS POLICY AN: HMO______________ PPO______________ POS______________

ADDRESS OF INSURANCE COMPANY______________________________

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PLEASE NOTE: If you register as a private patient and later want your case converted to a Workers' Compensation Claim or a No Fault Claim there will be a $500.00 fee to you for all of the administrative work involved.

EFFECTIVE: JANUARY 1ST, 2012

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF THE CO-PAYMENT IS NOT PAID AT THE TIME OF SERVICE AN ADDITIONAL ADMINISTRATIVE FEE OF $15.00 WILL BE APPLIED TO YOUR ACCOUNT.

EFFECTIVE: JANUARY 1ST, 2012

AN ADMINISTRATIVE FEE OF $10.00 WILL BE CHARGED FOR ANY DISABILITY/MEDICAL FORMS FILLED OUT BY THIS OFFICE. PAYMENT IS DUE UPON RECEIPT OF THE FORM.

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I certify that the above information is correct to the best of my knowledge. I, the undersigned certify that I have insurance coverage with______________________________ and assign directly to Southern Westchester Orthopedics & Sports Medicine Assoc., P.C. all insurance benefits. I further understand that I will be responsible for any charges that are not covered by my insurance company. I also authorize release of any medical information to my Primary Care Physician and/or insurance company. I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

SIGNATURE______________________________ DATE ______________