Manhattan Podiatry Associates P.C.
NYC Foot & Ankle OBS, P.C.
REGISTRATION FORM

(Please Print)

Today's Date ____/____/____ PCP_____

PATIENT INFORMATION

Patient's Last Name **First** **Middle**

❑ Mr. ❑ Miss ❑Mrs ❑ Ms	Marital Status (**Circle One**) Single / Mar / Div / Sep / Wid	Birth Date / /	Sex ❑ M ❑ F

Address	Social Security #	Home Phone No. ( )
City State ZIP Code		E-Mail Address

Occupation	Employer	Business Phone No. ( )	Cell Phone No. ( )

Referred to Office by ❑ Doctor _____ ❑ Insurance _____ ❑ Internet

❑ Advertiseme _____ ❑Patient/Friend _____ ❑ Other _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

NAME OF PRIMARY INSURANCE

Policyholder's name.	Policyholder's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Policyholder ❑ Self ❑ Spouse ❑ Child ❑ Other _____

NAME OF SECONDARY INSURANCE Policyholder's Name	Group #	Policy #

Patient's Relationship to Policyholder ❑ Self ❑ Spouse ❑ Child ❑ Other

Medical Doctor's Name/Address

Current foot complaint/symptoms

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Manhattan Podiatry or insurance company to release any information required to process my claims. I acknowledge that I was provided and read (or had the opportunity to read)and understood ***The Notice of Privacy Practice***
am aware that the following information is available for viewing upon request;

- Information regarding the providers of care in this organization
- A copy of the Patient's Bill of Rights and Responsibilities
- Information regarding the grievance process
- Ownership of Practice
- DNR Policy
- JCAHO Information

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

INSURANCE CHECKS SENT TO THE PATIENT

I have been informed by Manhattan Podiatry Associates that the checks from my Insurance company may be sent directly to me.

These insurance carriers will send checks to the patient:

1. **Blue Cross/Blue Shield**
2. **Oxford Health Plans**
3. **Empire Plan(Government Workers)**
4. **GHI**
5. **United Health Care**

I AGREE TO GIVE THESE INSURANCE CHECKS TO MANHATTAN PODIATRY ASSOCIATES.

I understand that these checks from my insurance company are for services provided to me by either:

- **NYC Foot & Ankle OBS.PC**
- **Anesthesiologist: Barry Cohen**
- **Doctors:**

***Dr. Steven Abramow or Dr. John E. Mancuso or Dr. Mark Landsman**
Dr. Howard Shapiro or Dr. Howard Zaiff
Dr. Ben Dimichino or Dr. Brian Fanno

***Being a GROUP Practice the statement from the Insurance Carrier may have the name of a different doctor other than your main doctor.**

I AGREE AND ACKNOWLEDGE NOT TO CASH OR DEPOSIT THESE CHECKS.

****IN THE EVENT I FALSELY WITHOLD SUCH CHECKS I AGREE AND ACKNOWLEDGE THAT I AM ULTIMATLY RESPONSIBLE FOR THE AMOUNT OF THESE CHECKS DUE TO MANHATTAN PODIATRY OR ANY OF THE DOCTORS MENTIONED ABOVE.**

If I get insurance checks for services provided by Manhattan Podiatry Associates, NYC Foot & Ankle OBS, P.C. or any of the podiatrist or Anesthesiologist I agree to forward them to Manhattan Podiatry Associates.

_____ _____ _____

Print Name Sign Name Date