PATIENT INFORMATION FORM

ANTHONY G. CICCAGLIONE, M.D.

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(203) 874-7456

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(203) 371-0406

PATIENT NAME:________________ DATE OF BIRTH________ SEX__
ADDRESS:____
HOME TEL:____________ WORK TEL:__________ CEL #:__________
SOCIAL SEC #:____________________ MARITAL STATUS:__________
EMAIL:__________________________ REFERRED BY:______________

PRIMARY INSURANCE:______________ SUBSCRIBER:______________
INS. ID#:____________________
SECONDARY INSURANCE:____________ SUBSCRIBER:______________
INS. ID#:____________________
SUBSCRIBER NAME:____________________ RELATIONSHIP__________
PATIENT EMPLOYER & TEL:______________________________________
WHO TO CALL IN EMERGENCY: HOME TEL:______________ CEL:________
ADDRESS:________________________ RELATIONSHIP:______________
IS THIS VISIT ACCIDENT RELATED?________ YES ________ NO

MEDICAL

CHIEF REASON FOR VISIT:
____
DATE OF LAST PHYSICAL:________
FOOD/MEDICATION ALLERGIES?__
CURRENT MEDICAL CONDITIONS.____
HIGH BLOOD PRESSURE?__________
DIABETES?______________________
ANY MAJOR SURGERIES/HOSPITALIZATIONS?________

INSURANCE

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF INSURANCE BENEFITS.I ALSO ACKNOWLEDGE THAT IF MY INSURANCE DOES NOT COVER A SERVICE WHICH HAS BEEN PROVIDED, THAT I AM FINANCIALLY RESPONSIBLE FOR THAT SERVICE.

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL/OTHER INFORMATION TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED______________________________ DATE______________

ANTHONY CICCAGLIONE, M.D.'S CREDIT CARD POLICY

It is our policy to keep a credit card on file.

With the implementation of The Affordable Healthcare Plan, deductibles and copay costs are now being transferred to you. We will charge your credit card under the following situations:

1) Your insurance is invalid, and you are ineligible for services at our office, at the time of your visit.

2) You have an outstanding balance due to one or more of the following:
Your insurance applied our visit to your deductible amount
Your insurance applied a portion of your visit to your deductible, and left a co-insurance/copay, for which you are responsible.

2c) You have not provided us with the correct insurance info: incorrect insurance card, incorrect order of insurance being billed (i.e. primary insurance/2ndary insurance), expired insurance card, incorrect birth date of insured, etc. *******Insurance companies typically allow 6 months to bill correctly, for services. After this time limit, insurance companies will deny paying us for your services. It is your responsibility to provide us/insurance company with appropriate information to process your claim. If we have asked by mail/email for information, and it is not received within time filing limit, you will be responsible for payment of services.*******
We appreciate your cooperation in helping us get paid promptly for our services, and alleviating our billing and collection fees.

I am aware that a copy of my credit card will be kept on file, and that it will be charged for any non-covered services, copays and deductible amounts.

Signed Patient **Printed Patient Name**

______________________ ______________________

Date:______________

ACKNOWLEDGEMENT OF PRIVACY NOTICE AND ADVANCED DIRECTIVES (SEE BOTTOM OF PAGE)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Anthony G. Ciccaglione, M.D. has provided me with the Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this Notice, and I request the following restriction(s) concerning the use of my personal information:

____

____

Further, I permit a copy of this authorization to be used in place of the original.

Signed:____________________________________ Date: X____________

If not signed by patient, please indicate relationship to patient (e.g. spouse, parent/guardian)

Relationship:__________________________ Witnessed By:__________________

Internal Use Only:

If patient or patient's representative refuses to sign, acknowledgement of receipt of notice was presented to patient and sign below.

Presented on (date):________________________ (time)__________

By: Anthony G. Ciccaglione representative and title________________________

ADVANCED DIRECTIVES

Do you currently have a _____LIVING WILL; _____POWER OF ATTORNEY

Please notate "Y" or "N" above