PETER R. BODNAR, M.D., PLLC

PATIENT INFORMATION SHEET

Last Name	First Name	Middle Name	Male Female
Address	City	State	Zip

Home Phone	Cell Phone	Work Phone

Date of Birth	Social Security Number	Employer name / address - Status : FT / PT / Student / Retired / Unemployed

Responsible Party - Guarantor:	Address	Date of Birth
Social Security Number	Relationship To Patient	Phone Number

Primary Care or Referring Physician	Phone Number

Emergency Contact	Relationship To Patient	Phone Number

Primary Insurance Address - Policy Number - Group Number - Copay:$	Policy Holder Name, DOB, Relationship to patient
Secondary Insurance Address - Policy Number - Group Number - Copay:$	Policy Holder Name, DOB, Relationship to patient
Other:	**Pharmacy Name & Location**

AUTHORIZATION FOR : ASSIGNMENT OF BENEFITS ***RESPONSIBILITY FOR NON-COVERED SERVICES*** **RELEASE OF INFORMATION**

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS PAYABLE BY ANY FEDERAL OR STATE HEALTH CARE PROGRAM OR COMMERCIAL PAYER BE MADE EITHER TO ME OR ON MY BEHALF TO PETER R. BODNAR, M.D., PLLC FOR ANY SERVICES FURNISHED TO ME BY ITS PHYSICIANS OR EMPLOYEES AT ANY LOCATION. I AUTHORIZE PETER R. BODNAR, M.D., PLLC TO RELEASE TO ITS BILLING AGENTS, THE HEALTH CARE FINANCING ADMINISTRATION, ITS AGENTS AND MY INSURER, AS APPLICABLE, ANY INFORMATION (INCLUDING, BUT NOT LIMITED TO INFORMATION REGARDING DRUG AND ALCOHOL PROGRAM PARTICIPATION, DIAGNOSIS, PROGNOSIS, TREATMENT OR REFERRAL) NEEDED TO DETERMINE THESE BENEFITS, THE BENEFITS PAYABLE FOR RELATED SERVICES OR TO OBTAIN PAYMENT FOR SERVICES PROVIDED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT TO RELEASE AT ANYTIME, EXCEPT TO THE EXTENT RELIED UPON BY PETER R. BODNAR, M.D., PLLC OR THE DISCLOSURE IS AUTHORIZED BY LAW. THIS CONSENT TO THE RELEASE OF PATIENT INFORMATION REMAINS VALID UNTIL EXPRESSLY REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM PRIMARILY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES PROVIDED, WHETHER OR NOT MY INSURANCE PAYS FOR THEM, AND ANY COPAYS, DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. FAILURE TO PAY THIS PORTION WILL RESULT IN A COLLECTION FEE OF $15.00. NO SHOW FEES ARE $35.00 PER MISSED APPOINTMENT.

SIGNATURE________________________________ DATE ____________________

HIPAA: I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE________________________________ DATE ____________________