North Country Medical Associates
Gastroenterology and Hepatology
Paul Bermanski M.D. Richard Fried M.D. David Purow M.D
195 East Main Street Huntington, NY 11743 Ph: 631-549-8181 Fax: 631-385-8280

Patient Name:______________________________ Date:__________

Date of Birth:______________________________ Age:__________

Social Security Number: ________--________--________

Circle One: SINGLE MARRIED DIVORCED WIDOWED/WIDOWER

Street Address:____

City:________________________ State:________ Zip Code:__________

Home Number:(____)______________ Alternate Number:(____)____________

Email Address:____

Employer/Business Name:______________________________________

Employer/Business Address:____________________________________

Occupation:____

Primary/Referring MD:____________________Telephone:(_____)__________

Primary Insurance:____

Policy Holder:______________________Policy Holder D.O.B.:____________

Policy/Member ID #:______________________Group #:______________

Insurance Address:____

Secondary Insurance:____

Policy Holder:______________________ Policy Holder D.O.B.:____________

Policy/Member ID #:______________________Group #:______________

Insurance Address:____

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195 East Main Street, Huntington, NY 11743

Patient Name: ______________________________ **Date:** __________________

We have given the above named patient of copy of our Notice of Privacy Practices. We have answered any questions that they have regarding this form.

Signature of Patient: ____

Signature of Parent if patient is a minor: ___________________________

Date: __________________

If I so choose, I also allow medical information to be disclosed to the following person/persons:

Name: ____

Relationship to Patient: ________________________

Name: ____

Relationship to Patient: ________________________

Name: ____

Relationship to Patient: ________________________

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Patient Name: ______________________________ Date: __________________

Primary Insurance Member ID/Policy Number: ____________________________

I request that payments of authorized benefits be made to North Country Medical Associates for medical services provided by either: Paul Bermanski M.D, Richard Fried M.D., or David Purow M.D

I authorize the release of medical information to my insurance carrier and its' agents as required to process claims for benefits on my behalf.

I acknowledge that if I am seen without necessary insurance referrals or authorizations, I will be responsible for any balance(s) not covered by the insurance carrier. I understand that if my insurance coverage changes and/or is terminated it is my responsibility to notify North Country Medical Associates prior to my appointment.

I acknowledge that all co-payments are payable at time of visit, prior to seeing any medical provider. If the co-payment is not paid at time of visit, a $15.00 fee will be charged. If full payment is not received within 30 days, an additional $15.00 fee will be charged. All balances other than co-payments will be billed ONE time. If payment is not received within one month, a fee of $15.00 will be charged monthly. If there are any special circumstances where the payment is unable to be made, please contact our billing department.

Patient Signature: ____

Parent Signature (if minor): ____________________________________

North Country Medical Associates

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I understand and agree that:

- My appointment time is reserved for only me. I will be responsible for cancelling any appointment 24 hours in advance. I understand that the office will attempt to confirm my appointment in advance, but ultimately it is my responsibility to keep this appointment. I am aware that the office will charge a $50 fee for any missed appointments.
- Payment for services is expected when services are rendered. I may pay with cash, check, or credit card, (visa or mastercard). There is a $30 fee added for all checks returned for insufficient funds. All co pays will be collected at the appointment, as well as any balance due on the account.
- I am aware that any changes regarding my address, phone number, or insurance information must be communicated immediately to the staff so that my account is up to date and that the correct information can be billed to my insurance company.
- It is my responsibility to understand the coverage, benefits, and limitations of my insurance plan. I am aware that I will be responsible for anything that my insurance deems a "non-covered service."
- It is my responsibility to know if my insurance requires a referral for my visit, and it is my responsibility to secure that referral prior to the visit.
- Any balance on my account that is unpaid for more than 90 days goes to collection status, and a $15 statement fee will be added each month. In the event that my account goes into collection, I understand that I will be responsible for any and all costs of collection including attorney fees, legal fees, and interest accrued.
- If I have no insurance coverage, I am self-pay patient. Payment is expected at the time of service, unless prior arrangements have been made with the billing department. If labs are done, I am aware that there may be separate charges that I may be billed for later.

Name:________________________ Date of Birth:________________

Signature:______________________ Date:____________________