

Michael C. Piccarelli, DPM
Associate, American College of Foot & Ankle Surgeons
272 Slosson Avenue
SI, NY 10314
718-273-0123

PATIENT INFORMATION

NAME _____ SS# _____
DATE OF BIRTH ___/___/___
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE: HOME () _____ WORK () _____
CELL () _____
OCCUPATION _____
EMPLOYER / ADDRESS / TELEPHONE _____
HOW WERE YOU REFERRED? _____ () _____

INSURED PERSON (IF DIFFERENT THAN PATIENT)

NAME _____ RELATIONSHIP _____
DATE OF BIRTH ___/___/___ SS# _____
EMPLOYER _____ TELEPHONE () _____

MEDICAL INFORMATION RELEASE / ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Signature X _____ Date ___/___/___

I hereby authorize Dr. Piccarelli to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made to Dr. Piccarelli or to the party that accepts assignment.

I also agree that I am responsible for the fee of any services that are not covered by my carrier or any deductible that may apply. _____ (initial)

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature X _____ Date ___/___/___