ISRAEL A. AVILES M.D.
DAVID TENEMBAUM M.D.

90-01 A Roosevelt Avenue
Jackson Heights, NY 11372
718 - 396 - 2005

53-14 Roosevelt Avenue
Woodside, NY 11377
Fax - 718- 396 - 2006

Información del Paciente

Fecha _______________

Nombre___________________________________ SSN# _____-_____-________

Fecha de Nacimiento _____/_____/________ Sexo: H / M Estado Civil C / S / D / V

Direccion ____ Apt.__________

Ciudad __________________________ Estado _______________ Zip Code ______

Teléfono (______) ________-__________ Celular (______) _______-__________

Contacto de Emergencia ____________________________ (____)______-_______

Referido por Dr. _________________________________

Información del Seguro

Compania de Seguro _________________________________

Numero de Seguro ___________________________________

Nombre que aparece en el seguro ____

Relación al Paciente ____________________ Fecha de Nacimiento ____/____/____

Farmacia ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with
______________________________ and assign directly to
Dr. ISRAEL AVILES all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Responsible party signature

____

Relationship **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. ISRAEL AVILES** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine this benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____

Beneficiary Signature **Date**

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________ and assign directly to **Dr. ISRAEL AVILES** all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible party signature

____

Relationship **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. ISRAEL AVILES** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine this benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____

Beneficiary Signature **Date**