S.T.A.R.S. of Westchester

A division of *WOHG, P.C.*

APPT:_____

THERAPIST:_____

MR #:_____

❒ NEW PATIENT or ❒ UPDATING INFORMATION

PATIENT INFORMATION

LAST NAME:_____ FIRST:_____ MIDDLE:_____

S.S. #:_____–_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____ SEX: ❒ M ❒ F MARITAL STATUS:_____

PRIMARY CARE PHYISICAN:_____ PHONE #_____

ADDRESS:_____

REFERRING PHYSICIAN:_____ PHONE #_____

ADDRESS:_____

PATIENT PHONE #:_____ PATIENT WORK PHONE #:_____ EXT:_____

MOTHER'S NAME:_____ FATHER'S NAME:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ CO-PAY: $_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE:_____

SUBSCRIBER:

LAST NAME:_____ FIRST:_____ MIDDLE:_____

DATE OF BIRTH:_____ SEX: ❒ M ❒ F S.S. #:_____–_____

RELATIONSHIP TO PATIENT:_____

POLICY#_____ GROUP# AND/OR NAME:_____

SECONDARY INSURANCE:_____ CO-PAY: $_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE:_____

SUBSCRIBER:

LAST NAME:_____ FIRST:_____ MIDDLE:_____

DATE OF BIRTH:_____ SEX: ❒ M ❒ F S.S. #:_____

RELATIONSHIP TO PATIENT:_____

POLICY #_____ GROUP # AND/OR NAME:_____

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TERTIARY INSURANCE:_____ **CO-PAY: $**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____ **PHONE:**_____

SUBSCRIBER:

LAST NAME:_____ **FIRST:**_____ **MIDDLE:**_____

DATE OF BIRTH:_____ **SEX:** ❒ **M** ❒ **F** **S.S. #:**_____ **-**_____

RELATIONSHIP TO PATIENT:_____

POLICY #_____ **GROUP # AND/OR NAME:**_____

EMERGENCY INFORMATION

NAME: (not living with you)_____ **RELATIONSHIP:**_____

HOME PHONE #_____ **WORK PHONE #**_____

ADDRESS:_____

CITY, STATE, ZIP:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

PERMISSION FOR TREATMENT: Permission is hereby granted to the therapists of *STARS of Westchester,* to render such medical treatment as is deemed necessary.
RELEASE OF INFORMATION: To the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, *STARS of Westchester* may disclose portions of the patient's medical record and account to any person or corporation which is or may be liable for all or any portion of the patient's charges including but not limited to insurance companies, health care service plans, or worker's compensation carriers. The patient's medical record may also be released to the referring therapist to ensure continuity of medical care.
FINANCIAL AGREEMENT: In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. I understand and agree that any and all referral documentation and or information, if required by my insurance carrier, is my responsibility to obtain and provide to *STARS of Westchester,* by no later than the date of my appointment. I understand and agree that I am responsible for the deductible, co-insurance, and non-covered services as determined by the Insurer. Should the account be referred for collections, the undersigned shall pay reasonable attorney's fees and collection expenses.
ASSIGNMENT OF INSURANCE BENEFITS: I request my insurance carrier to pay to *STARS of Westchester* all benefits due me related to my pending claim for medical and physical therapy services.
MEDICARE'S AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this therapist or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have read and approved all of the above except for those items I have personally lined through and initialed.

Print Name: _____ **Signature:** _____ **Date:**_____

FOR OFFICE USE ONLY

DIAGNOSIS:_____ **REFERRING PHYSICIAN UPIN:**_____