Date_____

PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)

LAST NAME_____ **FIRST NAME**_____
HOME ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

DATE OF BIRTH_____

HOME_____**WORK**_____**CELL**_____

EMERGENCY CONTACT&TELEPHONE# _____
_____

OCCUPATION_____**EMPLOYED BY**_____

PHARMACY: _____

MARITAL STATUS M S D W SEP SPOUSE'S NAME_____

INSURANCE PLAN & ID #_____

POLICYHOLDER OF INSURANCE_____

DATE OF BIRTH OF POLICY HOLDER_____

EMAIL_____

I hereby authorize Comprehensive Island Medical Care LLC to release any and all medical information to my insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoke in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Comprehensive Island Medical Care LLC all money to which I am entitled for medical and/or surgical expense relative to the service rendered by CIMC, not to exceed by indebtedness to said physician and/or surgeon. It is understood that any money received from my insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctor for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

INSURED OR GUARDIAN SIGNATURE_____

PATIENT'S SIGNATURE_____

Guarantee Agreement

I hereby authorize Comprehensive Island Medical Care LLC to release any and all medical information to my insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoke in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Comprehensive Island Medical Care LLC all money to which I am entitled for medical and/or surgical expense relative to the service rendered by CIMC, not to exceed by indebtedness to said physician and/or surgeon. It is understood that any money received from my insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctor for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

INSURED OR GUARDIAN SIGNATURE_____

PATIENT'S SIGNATURE_____

WITNESS_____ DATE_____

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under title XV111 of the Social Security Act is correct. I authorize any holder of medical or other information regarding myself to release to the Social Security Administration, Health Care Financing Administration, it's Intermediaries or carriers; any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for all physician services to be made to the physician furnishing the services.

_____ _____

DATE **PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE**

_____

WITNESS

COMPREHENSIVE ISLAND MEDICAL CARE TODAYS DATE:

Name	**Hospitalizations or Surgeries**
Birthdate	
Contact #'s- Home Cell	
Current Medications	
	Drug Allergies
	Vaccines
	Flu
	Pneumonia
	TDAP
	Zoster
	Other

MEDICAL HISTORY

ALLERGIES/ HAYFEVER	DRUG /ALCOHOL ABUSE	SKIN DISORDER
ANEMIA / BRUISE EASILY	GOUT	SEXUAL / MENSTRUAL DYSFUNCTION
ARTHRITIS / RHEUMATISM	HEART MURMUR	STROKE
ASTHMA / WHEEZING	HIGH BLOOD PRESSURE	THYROID DISEASE
CANCER	HEPATITIS	TUMORS
CROHN'S / COLITIS	KIDNEY DZ OR STONES	ULCERS - GASTROINTESTINAL
DIABETES	MENTAL ILLNESS	OTHER
DIVERTICULOSIS	OSTEOPOROSIS	
DEPRESSION / ANXIETY	PROSTATE DISEASE	
DIZZINESS / FAINTING	SEIZURES	

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS	
				MOTHERS SIDE	FATHERS SIDE
ALCOHOLISM	❑	❑	❑	❑	❑
ASTHMA	❑	❑	❑	❑	❑
BLEEDING DISORDER	❑	❑	❑	❑	❑
CANCER	❑	❑	❑	❑	❑
DIABETES	❑	❑	❑	❑	❑
EPILEPSY / CONVULSIONS	❑	❑	❑	❑	❑
GLAUCOMA	❑	❑	❑	❑	❑
HEART DISEASE	❑	❑	❑	❑	❑
HIGH BLOOD PRESSURE	❑	❑	❑	❑	❑
KIDNEY DISEASE	❑	❑	❑	❑	❑
MENTAL ILLNESS	❑	❑	❑	❑	❑
MIGRANE	❑	❑	❑	❑	❑
OSTEOPOROSIS	❑	❑	❑	❑	❑
STROKE	❑	❑	❑	❑	❑
THYROID DISEASE	❑	❑	❑	❑	❑
OTHER	❑	❑	❑	❑	❑

SOCIAL HISTORY

Tobacco use Y/N how long __ how much Recreational drugs- circle Vegetarian/ Vegan

Alcohol- Y/N how often? Sexual orientation-

How many pregnancies? full term deliveries- Miscarriages- Abortions-

COMPREHENSIVE ISLAND MEDICAL CARE
6080 JERICHO TURNPIKE, #205
COMMACK, NY 11725
(631) 486-4834

Thank you for choosing our office for your medical care. We have written these policies in response to the numerous changes in health care plans as it pertains to patient responsibility. Rest assured the card will only be used if the patient's account has been delinquent for more than 90 days and no payment arrangements have been made.

OFFICE POLICIES, EFFECTIVE JANUARY 1, 2014

PRE-AUTHORIZED CREDIT CARD AUTHORIZATION

I AUTHORIZE DR. YANIRA RAZA AND COMPREHENSIVE ISLAND MEDICAL CARE TO KEEP MY SIGNATURE ON FILE AND TO CHARGE MY ACCOUNT IF THERE IS A BALANCE DUE ON MY BEHALF AS INDICATED ON THE EXPLANATION OF BENEFITS FROM MY INSURANCE CARRIER:

I UNDERSTAND THAT THIS FORM IS VALID UNLESS I CANCEL THROUGH WRITTEN NOTICE TO THE OFFICE OF DR. RAZA.

Credit Card Authorization The office requires a credit card to be kept on file as a back-up payment method in the event of bill nonpayment and Payment Plans. Credit Card Authorization Form will be updated annually. A copy of the credit card receipt will be mailed to you if we charge your account. Cards will only be charged if payments have not been received after 90 days. I am, therefore, granting permission for Yanira Raza, MD to charge my credit card as per the above parameters.

☐ Please send me a statement of my responsibility. I understand: A copy of the credit card receipt will be mailed to you if we charge your account. You have up to 90 days to make payment. If I do not send payment, please charge my account for the patient responsibility due as indicated on the explanation of benefits.

☐ Please establish a monthly payment plan by charging my credit card automatically monthly in the amount of $_____ per month until the balance is paid in full.

PATIENT NAME

CARDHOLDER NAME (PERSON RESPONSIBLE FOR PAYMENT)

CARDHOLDER ADDRESS

CITY **STATE** **ZIP**

SWIPE CARD expiration date: ***circle Amex Visa Mastercard other***

CARDHOLDER SIGNATURE **DATE**