BridgeSpan Medicine

for teens and young adults

DATE: _____

PATIENT: LAST NAME_____ FIRST NAME_____ BIRTHDATE _____

MOTHER'S INFORMATION

LAST NAME:_____ FIRST NAME:_____

SS#:_____ BIRTHDATE: _____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE: _____CELL/WORK PHONE:_____

EMPLOYER: _____OCCUPATION: _____

EMAIL ADDRESS:_____

FATHER'S INFORMATION

LAST NAME:_____ FIRST NAME:_____

SS#:_____ BIRTHDATE: _____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE: _____CELL/WORK PHONE:_____

EMPLOYER: _____OCCUPATION: _____

EMAIL ADDRESS:_____

INSURANCE CARRIER:_____ PLAN TYPE:_____

ID#:_____ GROUP #:_____

WHO IS THE POLICY HOLDER? MOTHER/FATHER:_____ BIRTHDATE:_____

CO-PAYS ARE DUE AT TIME OF VISIT.

BridgeSpan Medicine PLLC 222 N. Westchester Ave, Suite 201 White Plains, NY, 10604
Phone: 914-698-5544 Fax: 914-698-4847 fax Email: BridgeSpanMedicine@gmail.com
Web: www.BridgeSpanMedicine.com

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PATIENT: LAST NAME_____ FIRST NAME_____ BIRTHDATE _____

Permission to Release Medical Information & Assignment of Benefits

I have read this registration form and state that all information given by me is known to be valid and true. I have read and understand the payment policy of *Bridgespan Medicine PLLC* and agree to their terms. A photocopy of this release/ assignment may be used in lieu of the original.

I authorize Bridgespan Medicine PLLC and the office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Parent/Guardian Signature: _____Date: _____

Payment Policy:

***Please read & sign the section below that corresponds to your benefit situation:**

I, _____, UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SELECT DR. KAREN J. BROWNER-ELHANAN AS MY CHILD'S PRIMARY CARE PHYSICIAN WITH MY INSURANCE COMPANY PRIOR TO VISIT. FAILURE TO NOTIFY MY INSURANCE COMPANY MAY RESULT IN ANY INCURRED CHARGES BEING MY FINANCIAL RESPONSIBILITY.

If Dr. Karen J. Browner-Elhanan is not available, you may choose to see Doctor Avvocato or Ross at BridgeSpan Medicine PLLC, all of whom are covered under this agreement.

- Not Insured: If you do not have insurance coverage or have coverage we do not accept, please understand that our payment policy is that *payment is due in full on the date of service*. You may make payment by cash, check or credit card.
- Cancellation: There will be a 24 hour cancellation policy for cancelled appointments. If appointments are missed without cancellation, you will be responsible for a $25.00 cancellation fee.
- Returned Check Policy: We accept personal checks as a form of payment. However, if the check is returned to us, a $25.00 returned check fee will be added to the patient's account.
- Co-pay Policy: As per your insurance company, you are required to pay your co-pay at the time visits are rendered. Please note that effective January 1st, 2010, a $20.00 processing fee will be added to the patient's account for each co-pay that is not paid at the time of service. If you do not pay at time of visit, your credit card will be charged.
- Referrals: If your insurance company requires a referral to visit a specialist, it is your responsibility to notify Bridgespan Medicine, PLLC and Dr. Karen J. Browner-Elhanan, 48 hours prior to the appointment so that we can process your referral. You will need to obtain the specialist's information in order to process your referral. Same day referral will only be issued if it is considered a medical emergency.

Parent/Guardian Signature: _____Date: _____

Credit Card Type:_____Credit Card #_____ CVV: _____Exp Date: _____

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