

EAST COAST RHEUMATOLOGY, PLLC
PREM C. CHATPAR, M.D., LLC AND ASSOCIATES

877 Stewart Avenue
Garden City, New York 11530
(516) 745-0202

524 Old Country Rd
Plainview, New York 11802
(516) 931-3988

5 East Main Street
Huntington, NY 11743
(631) 629-4588

PATIENT INFORMATION

NAME: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT/NEAREST RELATIVE: _____

D.O.B.: ___/___/___ AGE: ___ STATUS: S M W D EMAIL ADDRESS: _____

EMP. NAME: _____ S.S # _____ SEX: _____ **Referring M.D. or P.C.P** _____

RESPONSIBLE PARTY (INSURED) INFORMATION
(IF SAME, WRITE SAME)

NAME: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

D.O.B.: ___/___/___ S.S # _____ SEX: _____

EMPLOYER: _____ PATIENT RELATIONSHIP: _____

INSURANCE INFORMATION

PLEASE SHOW US ANY INSURANCE CARDS YOU HAVE, AND **FILL IN THE FOLLOWING INFORMATION:**

PRIMARY:

INSURANCE NAME: _____ INSURED PARTY: _____

ADDRESS: _____ INS. ID #: _____

SECONDARY:

INSURANCE NAME: _____ INSURED PARTY: _____

ADDRESS: _____ INS. ID #: _____

- 1.) I hereby authorize the practice of PREM C. CHATPAR, M.D., LLC to furnish any and all records pertaining to medical history, services, rendered or treatment given to me or my dependents for purposes of review, investigation, or evaluation of claims.
- 2.) I agree that any services that are rendered by PREM C. CHATPAR, M.D., LLC, OR HIS ASSOCIATIES beyond the normal scope of medical care will be billed additionally. This additional charge will be incurred for Disability Reviews, Insurance Examination Statements, Social Security Evaluations, Disability Evaluations and records requested by counsel, at your request. (A schedule of fees will be made available to you at your request.)
- 3.) I authorize payment of medical benefits to the practice of PREM C. CHATPAR, M.D., LLC.
- 4.) I hereby agree if my insurance carrier does not in any circumstance, reimburse PREM C. CHATPAR, M.D., LLC at contracted rate or honor the claim; I will be responsible in full for payment for all services rendered.
- 5.) I also understand that a \$25.00 no show fee can be charged for cancellation of appointments with less than 24-hour notice.

PATIENT OR AUTHORIZED SIGNATURE (REQUIRED): _____ **DATE:** _____ **2012** NEWPT.115