ARTHRITIS CONSULTANTS OF TIDEWATER

RHEUMATOLOGY · OSTEOPOROSIS · INTERNAL MEDICINE
PHONE (757) 491-7359 · FAX (757) 491-9359

GARY R. SEIGEL, M.D., F.A.C.R.
MICHAEL R. CANNON, M.D.
JANICE SHERWOOD, M.D., F.A.C.R.
TATIANA KECK, M.D.
FREDILYNN LANSANGAN, N.P.-C.

INSURANCE INFORMATION

Primary Insurance: _____

ID# _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Secondary Insurance: _____

ID# _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Third Insurance: _____

ID# _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

Medicare Part D Prescription Plan:

Prescription Insurance: _____

ID# _____ Group # _____

Subscriber's Name _____ DOB _____ SS# _____

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PAYMENT OF MEDICARE/MEDICAID BENEFITS:

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to Arthritis Consultants of Tidewater for services rendered. I authorize Arthritis Consultants of Tidewater to release the Health Care Financing Administration and its agents, any medical information needed to determine benefits or the benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of medical benefits to Arthritis Consultants of Tidewater for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I consent to the use or disclosure of my protected health information by Arthritis Consultants of Tidewater and if needed information from other providers, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the healthcare operations of Arthritis Consultants of Tidewater. I understand that diagnosis or treatment of me by Arthritis Consultants of Tidewater may be conditioned upon my consent as evidenced by my signature on this document.

CANCELLATION POLICY:

If you are unable to make your appointment, please notify our office one day (24 hours) prior to the appointment. We reserve the right to charge a $25 fee for missed appointments.

Patient's Signature: _____ Date: _____

If minor:

Guardian's Signature: _____ Date: _____