MAURICIO E. MELHADO, M.D., P.A.

3472 Forest Hill Blvd, Suite 3-B **561-619-3051**
West Palm Beach, FL 33406

PATIENT INFORMATION: PLEASE PRINT AND ANSWER ALL QUESTIONS

PATIENT'S NAME_____
(LAST) (FIRST) (MIDDLE)

GUARANTOR (IF PATIENT IS CHILD)_____

FL. ADDRESS_____APT#_____

CITY_____ST_____ZIP_____PH#_____

SS#_____DATE OF BIRTH_____SEX_____

SEASONAL ADDRESS_____APT#_____

CITY_____ST_____ZIP_____PH#_____

MARITAL STATUS_____NATIVE LANGUAGE_____DRIVER'S LICENSE#_____STATE_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____PH#_____

EMERGENCY CONTACT_____PH#_____

PHARMACY (PHONE NUMBER/ADRESS)_____

INSURANCE INFORMATION

PRIMARY
NAME OF INSURANCE CO._____PH#_____

ADDRESS OF INSURANCE CO._____

IF GROUP INSURANCE, PLEASE SPECIFY WHICH EMPLOYER CARRIES IT_____

NAME OF INSURED_____POLICY#_____

GROUP#_____MEDICARE#_____AUTH#_____

SECONDARY
NAME OF INSURANCE CO._____PH#_____

ADDRESS OF INSURANCE CO._____

IF GROUP INSURANCE, PLEASE SPECIFY WHICH EMPLOYER CARRIES IT_____

NAME OF INSURED_____POLICY#_____

GROUP#_____AUTH#_____

ASSIGNMENT OF BENEFITS

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to _____, M.D., P.A. who accepts assignment of benefits.

_____DATE_____
(Patient's or Authorized person's Signature)

REFERRING PHYSICIAN INFORMATION

NAME_____PH#_____
(LAST) (FIRST) (MI)

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of Mauricio E. Melhado, M.D., P.A and it is the responsibility of the staff to carry out instructions of such physician.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Mauricio E. Melhado, M.D., P.A. accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. **I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay.** It is further agreed that any credit balance resulting from payment of insurance or other source may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

RELEASE OF INFORMATION

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient of physician(s) charges, including but limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient' employer.

MEDICARE AND THE MEDICAID PATIENT IDENTIFICATION-AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to be released to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request payment for authorized benefits are made on my behalf. I assign the benefits payable for physician(s) services. **I understand that I am responsible for my health insurance deductibles and co-insurance.**

_____ _____
PRINT PATIENT'S NAME DATE

_____ _____
WITNESS PATIENT SIGNATURE OR REPRESENTATIVE

PATIENT UNABLE TO SIGN DUE TO:_____