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INFORMACJA O PACIENCIE

NAZWISKO _____ IMIĘ _____ ____
SS#_____-_____-_____ DATA URODZENIA _____/_____/_____
PŁEĆ M □ K □ WIEK _____
ADRES _____ APT#_____
MIASTO _____ STAN _____ KOD POCZTOWY _____
NARODOWOŚĆ _____ RELIGIA _____
TELEFON DOMOWY #_____ TELEFON KOMURKOWY # _____
ADRES EMAIL _____

WOLNY □ ŻONATY/ MĘŻATKA □ WDOWA/WDOWIEC □ ROZWIEDZONY □

PRACODAWCA _____ _____
ZAWÓD _____
ADRES PRACODAWCY _____
MIASTO _____ STAN _____ KOD POCZTOWY _____
TELEFON PRACODAWCY #_____

W RAZIE NAGŁEGO PRZYPADKU, OSOBA KONTAKTOWA _____
TELEFON #_____

LEKARZ RODZINNY _____
ADRES _____ POKÓJ#_____
MIASTO _____ STAN _____ KOD POCZTOWY _____
TELEFON #_____

UBEZPIECZENIE

PPO □ HMO □ MEDICARE □ MEDICARE REPLACEMENT □ MEDICAID □ UNION□ BEZ UBEZPIECZENIA □

NAZWA UBEZPIECZENIA_____
ID# _____ GROUP# _____
ADRES_____TELEFON #_____
POSIADACZ UBEZPIECZENIA _____ POKREWIEŃSTWO_____
SS#_____-_____-_____ DATA URODZENIA_____ PRACODAWCA_____

DODATKOWE UBEZPIECZENIE

NAZWA UBEZPIECZENIA_____
ID# _____ GROUP# _____
ADRES_____TELEFON #_____
POSIADACZ UBEZPIECZENIA _____ POKREWIEŃSTWO_____
SS#_____-_____-_____ DATA URODZENIA_____ PRACODAWCA_____

UBEZPIECZENIE NA LEKI

NAZWA UBEZPIECZENIA _____TELEFON _____
ID# _____ GROUP# _____

AUTHORIZATION OF TREATMENT

Niniejszym wyrażam zgodę, aby lekarz Maciej Drazkiewicz M.D., pielęgniarki oraz personel pozostający pod lekarza kierownictwem Zastosowali takie środki i sposoby leczenia oraz leki, które uznają za konieczne lub wskazane. Wyrażam tez zgodę na udzielanie informacji mojemu pracodawcy, przyszłemu pracodawcy i/lub firmie ubezpieczeniowej odnośnie mojego leczenia w tutejszej placówce.

Signature of Patient/Guardian: _____ **Date:** _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance/employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly Dr. Maciej Drazkiewicz all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies/employee health care plan any claim, chose in action, or other right I may have to such insurance/ employee health care benefit plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers/employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers/employee health care plan in my name but such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian_____ **Date**: _____

MEDICARE AUTHORIZATION

Wyrażam zgodę aby ośrodek Macieja Drążkiewicza wysyłał do mojego ubezpiecznie "Medicare" rachunki za wizyty i za leczenie w tym ośrodku.

(I request that payment of authorized Medicare benefits will be made either to me or on my behalf to Dr. M. Drazkiewicz for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests the payment to be made and authorizes release of medical information necessary to pay the claim. . In Medicare assigned cases the physician or the supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, co-insurance, co-pays, and non-covered services. Co-insurance and deductible are based upon charge determination of the Medicare carrier.)

Beneficiary Signature: _____ Date: _____