Dr. Samuel Schwarz, M.D. **Dr. Michael Ammirati, M.D.**

Note: Patients are required to pay at the time of service. However, if we participate in your plan, we ask that you sign the payment order below….

PATIENT REGISTRATION

Nature of complaint/ Injury: _____

Patient's Name: _____

Address: _____
(Street) (Apt.) (City) (State) (Zip)

DOB: _____Social Security #_____

PATIENT: Male ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( )

Home phone: (_____)_____ Business phone: (_____)_____

Occupation: _____ Employer's Name:_____

Primary physician doctor: _____ Phone **#(_____)_____**

Your Email Address _____

INSURANCE # 1 **Relationship To Insured: Child ( ) Self ( ) Spouse ( )**
Name of Insurance Carrier: _____ Policy ID #_____
(SPOUSAL COVERAGE) HUSBAND/WIFE
Name of Policy Holder: _____ DOB: _____

INSURANCE# 2

Name of Insurance Carrier: _____ Policy ID #_____

Name of Policy Holder: _____ DOB: _____

Insurance Payment Order:
I Authorized My Insurance Company to Pay Dr. Michael Ammirati or Dr. Samuel Schwarz all benefits due to me. This Policy was in full force and in effect at the time of treatment. I understand that I am financially responsible for all balances remaining after the payment of possible insurance benefits and that, should it become necessary, any and all reasonable collection/ attorney fees will be added to the patient's bill. I permit a copy of this authorization to be used in placed of the original.

Legal Signature: _____Date: _____

MEDICARE PATIENTS ONLY

I request that payment of authorized MEDICARE BENEFITS be made either to me or on my behalf to _____ for services furnished to me by the provider. 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 or the benefits payable for related services.

Patient Signature_____ Date_____

PLEASE INITIAL AFTER READING:

I was given, and thoroughly explained my insurance benefits (ALL IN AND OUT OF NETWORK responsibilities, and/or co-insurances) and I understand that I can ask the staff members any questions I may have PRIOR to my examination by the doctor (YES) _____

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Patient consent for Use and Disclosure of Protocol Health Information

I hereby give my consent for the office of Schwarz and Ammirati Medical Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by the office of Schwarz and Ammirati Medical Associates describes such uses and disclosures more completely.)

I have seen and been able to review the Notice of Privacy Practices prior to signing this consent and acknowledgement form. The office of Schwarz and Ammirati Medical Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Staff Members.

I agree that any information obtained during any endoscopic examination may be collected and used for research purposes provided that any information that leaves the confines of Schwarz and Ammirati Medical Associate's office is completely anonymous without any identifiers.

With this consent, the office of Schwarz and Ammirati Medical Associates may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice such as appointment reminders and insurance items. I also authorize the sending of mail to my home or other alternative location of any items that assist the practice in carrying out health care operations such as patient statements as long as they are marked "Personal and Confidential."

I have the right to request that the office of Schwarz and Ammirati Medical Associates restrict how it uses or discloses my PHI. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow the office of Schwarz and Ammirati Medical Associates to use and disclose my PHI to carry out their health care operations. I acknowledge that I have been given an opportunity to retrieve the Notice of Privacy Practices of Schwarz and Ammirati Medical Associates.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signed by: _____***Date:***_____

***Print Patient's/Guardian's Name*: _____*Date*: _____**

I give permission to Schwarz and Ammirati Medical Associates and staff to discuss my PHI with the person who accompanies me to the office (yes/no); my spouse (yes/no); my children (yes/no) my friends (yes/no)

Names of friends: _____