Curtis A. Raskin, M.D., Inc. 2700 Grant St., Suite 309, Concord, CA 94520

BILLING INFORMATION - PLEASE PRINT

Dr. _____
Mr. _____ Birth Date: _____ Age: _____ Sex: _____
Mrs. ____ Married ____ Sep _____ Sing _____ Div _____ Wid _____
Miss _____ Phone (Home): _____
Ms. _____ Phone (work/other): _____

Patient Name _____
last first middle
Address: _____
Street City State Zip
Has this office ever rendered treatment to any member of your family? _____
Name
Referred by: Dr. _____ Friend_____ Relative_____
Phone Book _____ Other _____

POLICY HOLDER INFORMATION

Policy Holder Name: _____ Birth Date: _____
Employer: _____
Address: _____
Street City State Zip
Phone (Home): _____ Phone (work/other): _____

I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered a chance to read, review and if desired take a copy of Curtis A. Raskin, MD, Inc.'s Notice of Privacy Practices.

_____ _____
Signature of Patient Date

PATIENT BILLING AGREEMENT

This acknowledges that you have been informed that our bookkeeping department will attempt to bill your insurance as a courtesy to you. In the event that your insurance denies your claim for any reason, the patient is responsible for any portion not covered by your insurance company. We also charge a $20 returned check fee (this is in addition to any bank fees we incur).

Patient Signature: _____ Date: _____

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MEDICARE SIGNATURE RECORD

This is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that the payer requires for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration (or its intermediaries or carrier) any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits only apply.

_____ _____

Signature as it appears on Medicare card Date

MEDICARE SUPPLEMENT SIGNATURE RECORD

If you have a supplemental policy and it is a Medigap policy to which your Medicare carrier automatically “crosses over,” we are required to keep a separate signature on file:

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on Medicare card Date