Michael C. Gordon MD LLC
New Patient Information

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _
STREET ADDRESS:
_____
CITY/STATE/ZIP:
_____
DOB: _____ SOC.SEC.#: _____ OR DRIVERS LIC #: _____
PHONE NUMBER: HOME: _____ CELL: _____ EMAIL:
_____
AGE: _____ SEX: M or F MARITAL STATUS: S M D W OTHER
SPOUSE'S NAME:_____

ALLERGIES:
_____

PATIENT'S EMPLOYER: _____ PH #: _____
STREET ADDRESS:
_____
CITY/STATE/ZIP:
_____
PATIENT'S OCCUPATION:
_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT):

LAST NAME: _____ FIRST NAME: _____ MI: __
STREET ADDRESS:
_____
CITY/STATE/ZIP:
_____
DOB: _____ SOC.SEC#: _____ OR DRIVERS LIC #: _____
CONTACT PHONE #: CELL _____ HOME: _____

R/P EMPLOYER: _____ PH#: _____
STREET ADDRESS:
_____
CITY/STATE/ZIP:
_____
R/P OCCUPATION:
_____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ PH #: _____
STREET ADDRESS:

_____
CITY/STATE/ZIP:

_____
INSURED'S NAME: _____ DOB: _____
POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ PH #: _____
STREET ADDRESS:

_____
CITY/STATE/ZIP:

_____
INSURED'S NAME: _____ DOB: _____
POLICY #: _____ GROUP #: _____

IS TODAY'S VISIT THE RESULT OF A WORK RELATED INJURY? YES OR NO DATE OF INJURY: _____
WORKER COMP CLAIM #: _____ CONTACT INFORMATION: ADJUSTER: __
_____ PH #: _____ ATTORNEY/PH #: _____

IS THIS VISIT THE RESULT OF A CAR ACCIDENT: YES OR NO DATE OF ACCIDENT: _____
ATTORNEY/CONTACT INFO:

_____

WHO CAN WE THANK FOR REFERRING YOU TO US?

_____

I UNDERSTAND THE OFFICE WILL FILE ALL INSURANCE CLAIMS AND WORK WITH THE INSURANCE COMPANY TO INSURE PAYMENT FOR SERVICES IN THE OFFICE. HOWEVER, I UNDERSTAND THAT SHOULD MY INSURANCE COMPANY DENY MY CLAIMS I WILL BE FINANCIALLY RESPONSIBLE FOR THESE SERVICES.

PATIENT OR RESPONSIBLE
PARTY SIGNATURE: _____ DATE: _____

INSURANCE AUTHORIZATION:

I, THE UNDERSIGNED, HAVE COVERAGE WITH _____
INSURANCE COMPANY, AND I ASSIGN BENEFITS DIRECTLY TO MICHAEL C GORDON MD LLC, FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE MICHAEL C GORDON MD LLC TO RELEASE ALL INFORMATION INCLUDING BUT NOT LIMITED TO PSYCHOTHERAPY NOTES, NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

PATIENT SIGNATURE: _____ DATE: _____

MEDICARE AUTHORIZATION:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO MICHAEL C GORDON MD LLC, FOR ANY SERVICES RENDERED. I AUTHORIZE MICHAEL C GORDON MD LLC TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT MY SIGNATURE BELOW AUTHORIZES THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM: IF "OTHER HEALTH INSURANCE" IS INDICATED ON THE APPROPRIATE HEALTH CLAIM FOR OR ELECTRONICALLY SUBMITTED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASE OF THIS INFORMATION TO THE INSURANCE OR AGENCY SHOWN. MICHAEL C GORDON MD LLC AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE FOR ONLY THE DEDUCTIBLE, COINSURANCE AND NON-COVERED SERVICES. COINSURANCE AND DEDUCTIBLE ARE BASED ON THE CHARGE DETERMINATION BY THE MEDICARE CARRIER.

PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZATIONS:

I HEREBY ACKNOWLEDGE AND CONSENT TO TREATMENT BY MICHAEL C GORDON MD LLC. SUCH TREATMENT MY INCLUDE BUT IS NOT LIMITED TO, DIAGNOSIS, PSYCHOTHERAPY, AND THE PRESCRIPTION OF MEDICATIONS. I HAVE THE RIGHT TO HAVE ALL ASPECTS OF MY DIAGNOSIS AND TREATMENT EXPLAINED TO ME IN LANGUAGE I CAN UNDERSTAND AND HAVE THE RIGHT TO REFUSE ANY COURSE OF TREATMENT RECOMMENDED BY MICHAEL C GORDON MD LLC.

PATIENT SIGNATURE: _____ DATE: _____