## Adult Information

**Patient's Name** _____
Last First Middle

Address _____ City _____ Zip _____

Phone _____ Cell _____

Work # _____ Employer _____

SS# _____ Date of Birth _____

Marital Status S___M___D___W___ Driver's License # _____

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**Spouse Name** _____
Last First Middle

Date of Birth _____ Phone # _____ SS# _____

Cell Phone# _____

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**Other than Spouse Emergency Contact**

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

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**Primary Insurance** _____

Name of Insured _____ Date of Birth _____

ID# _____ Group # _____

Claims Address _____

**Secondary Insurance** _____

Name of Insured _____ Date of Birth _____

ID# _____ Group # _____

Claims Address _____

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**Email** _____

**Pharmacy** _____

## Additional Family Members

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

## Medications

*We will not maintain any pain medications*

| Name of Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
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## Insurance Assignment and Release

Christopher E. Beney MD, PC
77 Elizabeth Drive
Lockport, NY 14094
(716) 433- 2674

**I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Dr. Beney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

**The above named physician my use my health care information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable to related services.**

_____

**Signature** **Date**

**PATIENT NAME** _____

**Christopher E. Beney MD, PC**
**77 Elizabeth Drive**
**Lockport, NY 14094**
**(716) 433-2674**

**Financial Policy**

We are committed to providing you with the best possible care and we are pleased to discuss our professional policies with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask any questions about our fees, financial policy or your responsibility.

- Full payment is due at the time of service
- All co-payments are due at the time of service. If this is not collected, an additional $5.00 will be charged
- We accept cash, check or credit card. Returned checks will have an additional charge of $20.00
- We no longer accept workman's compensation. We will try to provide a list of alternative physicians who do participate.
- Should your account be sent to collections, you will be responsible for all fees

**Insurance**

If you have insurance, we will help you receive the maximum benefits. However, **INSURANCE IS A CONTRACT BETEEWN YOU AND YOUR INSURANCE COMPANY.** We will inform you if we participate with your insurance company, and will handle your claims according to our agreement with them, if one exists. We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary.

**Appointments/Missed Appointments**

Appointments may be made once you have listed our physician as your primary care physician. If you are seen by our physician and have not changed your listing with your insurance company, you will be charged and expected to pay for the full office visit. We appreciate 24 hours notice to change an appointment. If you miss "no show" your appointment without notifying the office, you will be charged for the visit. If three (3) appointments are missed without notification, you will be asked to leave our practice. It is important that you are punctual for your scheduled appointments. If you are more than 15 minutes late, you may be asked to reschedule your appointment. Please help us to control health care costs by keeping your scheduled appointments.

**Thank you for understanding our Financial Policy**

**Permission to release medical information**

I give my permission to the office of Dr. Christopher Beney to disclose medical information regarding my treatment/diagnosis to the following person/persons.

Name_____ DOB_____ Relationship_____

Name_____ DOB_____ Relationship_____

Name_____ DOB_____ Relationship_____

**Patient's Name**_____ **Date of Birth**_____

**Responsible party (Print)** _____

**Signature** _____ **Date**_____