

**Park Place Medical Imaging, PC****Lisa A. Corrente, M.D.**316 East 30th Street
New York, New York 10016☐ New PT ☐ Follow-Up PT **Patients Chart****Date:**

Last Name:		First Name:		Middle Initial:			
Street Address:					Apt No.:		
City:			State:		Zip Code:		
Home Phone:			Cell Phone:			Date of Birth:	
Email Address:					SS No.:		
Marital Status:	☐ S	☐ M	☐ D	☐ W	☐ Domestic Partner	Sex:	☐ Female ☐ Male

REFERRING PHYSICIAN INFORMATION

Referring Physician:				NPI No.:				
Address:			City :		State:		Zip Code:	
Physician Phone:				Physician Fax:				

INSURANCE INFORMATION

Primary Ins.:				Secondary Ins.:				
Policy #:				Policy #:				
Group #:				Group #:				
Policy Holder:				Policy Holder:				
PH D O B:				PH SS No.:				
1 Ins Address:			City:		State:		Zip Code:	
2 Ins Address:			City:		State:		Zip Code:	

EMPLOYMENT INFORMATION

Employer's Name:				Position:				
Address:			City :		State:		Zip Code:	
Work Phone:				Work Fax:				

NO FAULT OR WORKER'S COMPENSATION INFORMATION

IS THIS A WORKER'S COMP. CASE?	☐ Yes ☐ No	IS THIS A NO FAULT CASE?	☐ Yes ☐ No		
Adjuster's Name:			Ins. Carrier:		
Tel No.:			Lawyer's Name:		
Fax No.:			Date of Accident:		
Claim No.:			Carrier No.:		
Authorization No.:			Procedure Type:		

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my examination or treatment to the Social Security Administration, its intermediaries or carriers (for Medicare Patients) and all other third party insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges if not paid by the insurance.

I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I understand that if I default, I will pay all of your expenses in enforcing or collecting this agreement. including reasonable attorney's fees.

Legal Signature:		Date:	
Legal Witness:		Date:	