WELCOME TO THE OFFICE OF
STUART B. CHERNEY, M.D., P.C.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY

290 E. MAIN STREET, SUITE 700
SMITHTOWN, NEW YORK 11787
(631)361-7867

Today's Date: ________________________

Referred By: _________________________

NO FAULT

PATIENT NAME: ____
AGE:______ BIRTHDATE:______________________ SS#: ___________________
HOME ADDRESS: ____
CITY/TOWN: ________________________ STATE: ______________________ ZIP: ___________
PHONE #:___________________________ CELL PHONE #: ____________________________

PRESENT COMPLAINT: ____

NO FAULT INSURANCE CO. NAME: ____
ADDRESS: ____
CITY/TOWN:____
STATE: ________________________ ZIP: _______________ PHONE #___________________
DATE OF ACCIDENT: _____________________________________
INSURED'S NAME: ____
POLICY#: ________________________________CLAIM#: _____________________________

ATTORNEY'S NAME: ____
ADDRESS: ____
CITY/ TOWN: ____
STATE: ________________________ ZIP: ______________ PHONE#: ___________________

HEALTH INSURANCE CO:____
ADDRESS:____
CITY/TOWN:____
STATE:_______________________ ZIP:________________ PHONE #: ___________________
INSURED PARTY:_________________________ INSURED BIRTHDATE:__________________
SS#:________________________ POLICY #:_________________ ID#: _________________

PLEASE READ : ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO SURGERY. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE STUART B. CHERNEY, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE:____ DATE:_________________