NEW HAVEN SURGICAL ASSOCIATES, P.C.

ACCT.# _____

136 Sherman Avenue, Suite 308
New Haven, CT 06511
Phone: 203-777-2375
Fax: 203-777-6916

John P. Amodeo MD FACS

General Surgery
Endoscopy
Laparoscopy

PATIENT INFORMATION

Referring MD: _____

Patient's Name: _____ Date of Birth: _____ SS# _____

Address: _____ Marital Status: _____
Street City State Zip Code

Home Tel# _____ Work# _____ Cell# _____

Please circle the telephone numbers we can leave a message on.

Employer Name: _____ Address: _____

Spouse's Name: _____ Date of Birth: _____ SS# _____

Work# _____ Cell# _____ Employer's Name: _____

Person to contact in case of emergency: _____ Tel# _____

May we release medical information regarding your condition to this person? Yes ___ No ____

Primary Insurance: _____ ID# _____ Grp# _____

Subscriber's Name: _____ Employer: _____

Secondary Insurance: _____ ID# _____ Grp# _____

Subscriber's Name: _____ Employer: _____

Preferred Pharmacy: _____ Tel# _____

PATIENT'S RESPONSIBILITIES: I request that payment of authorized benefits be made to New Haven Surgical Associates, PC (John P. Amodeo, MD) for any services rendered to me. I authorize the release of medical information to my insurance carrier(s) and/or referring or primary physicians. I release New Haven Surgical Associates, HCFA and its agents, or any other supplier of medical information held harmless in order to provide payable benefits for such services rendered. I understand a $10 service fee will be applied to my account for copayments that are not made at the time services are rendered. Additionally, I understand a 15% collection fee will be applied to any delinquency on my account which is 90 days past due, all costs of collection including attorney fees. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

I understand I will be responsible for a $50 charge for any appointment that is not cancelled within 24 hours prior to my appointment time.

I hereby acknowledge that I have reviewed the attached copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I may request a copy of any amended Notices of Privacy Practices at each appointment.

_____ _____

Patient's Signature Date: