Stony Brook Medicine

Patient Name: _____ MRN: _____

Group #: _____ Date: _____

CLINICAL PRACTICE MANAGEMENT PLAN

Patient Name: _____
Last First Middle

RELEASE OF INFORMATION

Last I hereby authorize and direct _____, University Faculty Practice corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X _____ Date: _____
Signature of Patient or Authorized Representative

UNIFORM ASSIGNMENT

I hereby assign, transfer and set over to _____, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopedic Associates, Stony Brook Children's Services, Stony Brook Psychiatric Associates, Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X _____ Date: _____
Signature of Patient or Authorized Representative

Account Representative: _____

MRN: _____ Date Updated: _____

Updated / Demographic Information

Patient Name: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Telephone #: _____
Daytime Telephone #: _____
Social Security #: _____
Date of Birth: _____

Responsible Party: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Telephone #: _____
Daytime Telephone #: _____
Social Security #: _____
Date of Birth: _____

Medical Insurance Information

"Primary" Insurance

Company Name: _____
Address: _____
_____
Telephone #: _____
Policy Holder: _____
Policy #: _____
Relationship to Patient: _____
Policy Holder's Date of Birth: _____
Policy Holder's Social Security #: _____
Employer Name: _____
Employer Address: _____
Effective Date of Coverage: _____
Primary Care Provider: _____
Telephone #: _____
Date of Birth: _____

"Secondary" Insurance

Company Name: _____
Address: _____
_____
Telephone #: _____
Policy Holder: _____
Policy #: _____
Relationship to Patient: _____
Policy Holder's Date of Birth: _____
Policy Holder's Social Security #: _____
Employer Name: _____
Employer Address: _____
Effective Date of Coverage: _____
Primary Care Provider: _____
Telephone #: _____
Date of Birth: _____

No Fault

Policy Holder: _____
Policy #: _____
Date of Accident: _____
Claim/File Accident: _____
NF Insurance Name: _____
Insurance Address: _____
_____
Insurance Carrier Telephone #: _____

Blue Shield and/or Blue Cross

Address: _____
Policy Holder: _____
Policy #: _____
Group #: _____

Worker's Compensation

Employer at the time of Accident: _____
Employer Name: _____
Employer Address: _____
_____
Employer Telephone #: _____
Social Security #: _____
WC Insurance Name: _____
Insurance Address: _____
_____
Date of Accident: _____
WCB #: _____
Carrier Claim: _____