## PETER R. BODNAR, M.D., PLLC PATIENT INFORMATION SHEET

					Male Female	
Address		City			Zip	
<u>Cell Phone</u>			Work Phone			
Date of Birth Social Security Number Employer na			ame / address - Status : FT / PT / Student / Retired / Unemployed			
Address				Date of l	Birth	
Relationship To Patient				Phone Number		
rimary Care or Referring Physician			Phone Number			
Relationship To Patient			Phone Number			
Primary Insurance Address - Policy Number - Group Number - Copay:S			Policy Holder Name. DOB, Relationship to patient			
Secondary Insurance Address - Policy Number - Group Number - Copay:S			Policy Holder Name. DOB, Relationship to patient			
Other:			Pharmacy Name & Location			
I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS *RESPONSIBILITY FOR NON-COVERED SERVICES* RELEASE OF INFORMATION  I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS PAYABLE BY ANY FEDERAL OR STATE HEALTH CARE PROGRAM OR COMMERCIAL PAYER BE MADE EITHER TO ME OR ON MY BEHALF TO PETER R. BODNAR, M.D., PLLC FOR ANY SERVICES FURNISHED TO ME BY ITS PHYSICIANS OR EMPLOYEES AT ANY LOCATION. I AUTHORIZE PETER R. BODNAR, M.D., PLLC TO RELEASE TO ITS BILLING AGENTS, THE HEALTH CARE FINANCING ADMINISTRATION, ITS AGENTS AND MY INSURER, AS APPLICABLE, ANY INFORMATION (INCLUDING, BUT NOT LIMITED TO INFORMATION REGARDING DRUG AND ALCOHOL PROGRAM PARTICIPATION, DIAGNOSIS, PROGNOSIS, TREATMENT OR REFERRAL) NEEDED TO DETERMINE THESE BENEFITS, THE BENEFITS PAYABLE FOR RELATED SERVICES OR TO OBTAIN PAYMENT FOR SERVICES PROVIDED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT TO RELEASE AT ANYTIME, EXCEPT TO THE EXTENT RELIED UPON BY PETER R. BODNAR, M.D., PLLC OR THE DISCLOSURE IS AUTHORIZED BY LAW. THIS CONSENT TO THE RELEASE OF PATIENT INFORMATION REMAINS VALID UNTIL EXPRESSLY REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM PRIMARILY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES PROVIDED, WHETHER OR NOT MY INSURANCE PAYS FOR THEM, AND ANY COPAYS, DEDUCTIBLES ARE \$35.00 PER MISSED APPOINTMENT.						
SIGNATURE_			DATE			
HIPAA: I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES.  SIGNATURE DATE						
HIPAA: I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES.						
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