Southampton Osteopathy
349 Meetinghouse Lane
Southampton, NY 11968
631.377.3630

Date: _____/ _____ / _____

Patient Name _____ Sex: Male/ Female Date of Birth _____

Marital Status _____ Social Security # _____

Address:_____

Home Phone _____ Cell Phone_____Work _____

Primary Insurance Company _____Policy Holder's Name _____

Insurance Policy ID #_____ Group #_____

Secondary Insurance Co _____ Policy Holder's Name _____

Policy Holder's Date of Birth_____ Social Security #_____

Workers Compensation: Date of Accident _____ Employer Name _____

Employer Address & Phone _____

Workers Comp Insurance Company_____Phone_____

Workers Comp Insurance Address _____

Workers Comp Case # _____ Workers Comp # _____

No Fault – Date of Accident _____ Claim#_____

Policy #_____ Insurance Carrier_____Address_____

Medicare Lifetime Signature on File : I request payment of authorized Medicare benefits by made on my behalf to Dr. Stephen Braun D.O. for any services furnished by the physician. I authorize any holder of medical information about me released to the Health Care Financing Administration and its agents any information to determine these benefits related service**. _____ (Initial)**

Insurance Authorization for Assignment of Benefits I, the undersigned, authorize my treatment by Southampton Osteopathy and payment of benefits to Dr Stephen Braun D.O. for services provided by the physician. I understand I am financially responsible for any amount not covered by my contract. I also authorize release of my health information to my insurance company or their agent. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature_____ Date _____

- **Parent or Guardian (Child under 18)**

Cancellation Policy – We require 24 hours notice to cancel an appointment without penalty. I understand cancellation without proper notice will incur a $50.00 charge _____