Steven A. Chismar, MD, FACOG

PATIENT MAINTENANCE, ASSIGNMENT OF BENEFITS & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Personal Information

Name: First:___________________ Middle Initial____ Last Name___________________

Street:____ Apt:_____________

City:__________________________________ State:__________ Zip Code:________

Marital Status: M S D W (circle one) SSN: ______/____/_______ DOB:___________

Referred by ________________________Medical Doctor:_________________________

Home phone: (_____) ________________ Alternate : (_____) ________________

Work : (_____) ________________ Employer_____________________ City ___________

Emergency Contact:____

Phone:(_____)________________ Relationship:_________________________________

Preferred Drug Store ____________________________ City ______________________

Insurance Information –complete if insured through spouse or family member (subscriber)

Subscriber: ___________________________ Relationship:______________________

Subscriber Address Street:___________________________________ Apt:___________

City:__________________________________ State:__________ Zip Code:________

Subscriber DOB: ___________________ Subscriber SSN: ______/____/_______

Home phone: (_____) ________________ Work : (_____) ________________

Subscriber Employer_____________________________________ City _______________

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including Medicaid, Medicare, private insurance and other health plans to Dr. Steven A. Chismar. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assignee to release all information necessary to secure payment.

Patient Signature: ___________________________________ Date: _________________

I have received a copy of Steven A. Chismar, M.D.'s Notice of Privacy Practices.

Patient Signature: ___________________________________ Date: _________________

200 Medical Park, Suite A2
Dover, Ohio 44622