

Payment Policy Statement

The following is a statement of our financial policy.

Participating Providers: This means that the physician you will see accepts your insurance.

- Please present insurance card
- Co-payments are **DUE AT TIME OF SERVICE**
- The patient or guarantor will be held responsible for any deductibles, co-insurance, or any other financial obligations dictated by your insurance contract. It is the patient's responsibility to know the terms of their insurance contract.
- The patient acknowledges that any charge not covered by their insurance is their financial responsibility
- Patients without insurance card(s) and valid referrals may be asked for payment in full at time of service if their insurance cannot be verified.

Non-Participating Providers: This means that the physician you will see does NOT accept your insurance.

Payment for all services related to the visit is DUE AT TIME OF SERVICE. You will be provided with a receipt for you to submit to your insurance. Please be aware of what your contract is with your insurance. If you do not have out of network benefits you will not be eligible for reimbursement from your insurance company.

The following methods of payment are provided for your convenience:

- Cash
- Checks
- All major credit cards (Visa, Mastercard, American Express, Discover)

I have read the payment policy; I fully understand and agree to it.

Patient Name (Please Print)

Patient Signature



Gregory R. Brevetti MD, PC
631-353-0909
Port Jefferson | West Islip | Amityville

Patient Demographics

Name: _____ Date of Birth: _____

Social Security #: _____

Gender identity: Male _____ Female _____ Prefer not to specify _____

Race / Ethnicity: _____

Home Phone#: _____ Mobile #: _____

Address: _____ City: _____ Zip: _____

Email: _____

Pharmacy: _____ Phone#: _____

Pharmacy address: _____ City: _____ Zip: _____

Primary Insurance: ***Please present to front desk upon arrival***

Next of Kin: _____ Relationship to patient: _____

Contact #: _____

Emergency Contact: _____ Phone#: _____

Relationship to patient: _____

How were you referred to us? _____



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Pulmonologist: _____

Primary Care: _____

Cardiologist: _____

Oncologist: _____

Other Specialty: _____

Social History

Smoker: _____ Non-Smoker: _____ Quit year: _____

Alcohol use: _____ drink(s) per day _____ No alcohol use: _____

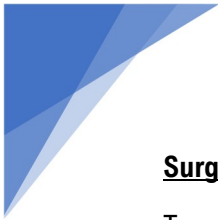
Recreational Drug use: _____ Type: _____ Never: _____

Family Health History

Relative: _____ Condition: _____

Allergies (List type and reaction)

Medication / Environmental: _____ Reaction: _____



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Surgeries (List Type and Date)

Type of Surgery: _____ Date of Surgery: _____

Ongoing Medical Problems (i.e., COPD, CHF etc.)

Medications

Name of Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Implantable Devices

Device Identifier: _____

Implant Date: _____

Active: _____ Inactive: _____

Asbestos Exposure Questionnaire



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Patient: _____ Date of Birth: _____

I authorize the following using or disclosing party: **Gregory R. Brevetti MD, PC** to use or disclose the following health information.

- All of my health information

- My health information relating to the following treatment or condition:

- My health information covering the period from _____ (date) to _____ (date)

Other: _____

This authorization ends: On (date) _____

A copy of this authorization is as valid as the original.

Patient Name (Print)

Patient or Legally Authorized Representative Signature

Date

Legally Authorized representative (Print)

Relationship to Patient

HIPPA Compliance

I have received Notice of Privacy Practices and PHI policy either electronically or in paper form.

Patient Name (Print)

Patient or Legally Authorized Representative Signature

Date

Legally Authorized representative (Print)

Relationship to Patient