Comprehensive Spine and Pain Center of New York

Tim Canty MD PLLC
www.NYSpinePainCenter.com
(917) 524-7246

Date _____ **Chart#**_____

Last Name _____ **First Name:** _____ **DOB** ___/____/___ **Sex** □ **F** □ **M**

Age _____ **SS#** _____ **Marital Status:** □ **M** □ **S** □ **D** □ **W**

Address_____ **Apt:** _____**City:** _____ **State:** _____ **Zip** _____

Home Phone (____) _____ **Mobile Phone:** (____) _____ **Work Phone:** (____) _____

Email Address: _____

Emergency Contact: _____ **_Relation:** _____ **Phone:** (____) _____

REFERRING PHYSICIAN:

Doctor's Name: _____ **Phone:** (_____) _____

Reason for your visit: _____

PRIMARY /FAMILY PHYSICIAN:

Doctor's Name: _____ _____ **Phone:** (_____) _____

PRIMARY INSURANCE INFORMATION:_____

Insurance Name: _____ **Plan Type: PPO** □ **POS** □ **EPO** □ **HMO** □ **Not Sure**

Policy #_____ **Group #** _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Phone: (_____) _____

Policy Holder's Name (if not self): _____ **Relation to patient:** _____**DOB:**_____

Deductible / Coinsurance_____

_____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ **Plan Type: PPO** □ **POS** □ **EPO** □ **HMO** □ **Not Sure**

Policy #_____ **Group #** _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Phone: (_____) _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. ***I understand that in the event that insurance benefits are paid directly to me, I will forward payment to Tim Canty MD PLLC with the understanding that if to do so within 90 days, it may be determined that the services of a collection agency and/ or attorney may be necessary to facilitate the collection of all past due charges. I agree to be responsible for all reasonable collection fees and costs associated with the collection of said past due balance(s) as well as "out of network" deductible payments for GHI, Aetna, Cigna plans if I that is my insurance carrier since Dr. Canty does not participate in those plans.*** **I also authorize Tim Canty MD PLLC or insurance company to release any information required to process my claims.**
I hereby authorize the treating physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company (ies).

_____ _____

Patient/ Guardian Signature ***Date***